

OFFICE OF POPULATION CENSUSES AND SURVEYS
SOCIAL SURVEY DIVISION

The Family Planning Services: changes and effects

A survey carried out on behalf of
the Department of Health and Social Security

Margaret Bone

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Margaret Bone

London : Her Majesty's Stationery Office



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Percentages have been rounded to the nearest whole number and therefore do not always add up to exactly 100.

.. represents less than 0.5 per cent.

NA = not asked

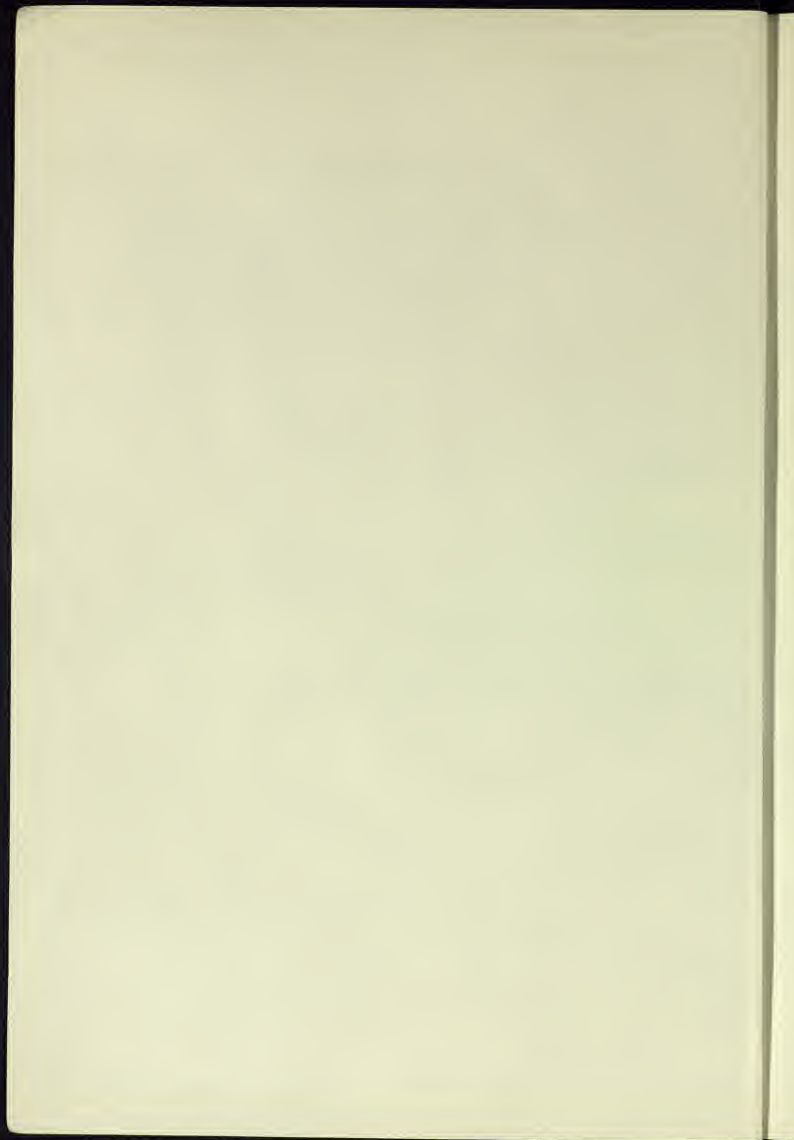
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1 Purposes and Method

1.1 Purposes of the Survey

Since 1970, when the first national survey of the use of Family Planning Services took place,¹ a major change in provision has occurred: the services and the methods they prescribe as well as the prescriptions themselves have been made free of charge. At the time the decision was taken by Parliament to remove charges, the Secretary of State for Health and Social Security undertook to monitor the progress of the services. The present survey, carried out for the Department of Health and Social Security, was designed to provide information of use to them in fulfilling this obligation.

The main aims of the present enquiry are of two kinds. Firstly, they are to describe service and contraceptive use in 1975 and the extent and form of changes in both, between the two surveys. Secondly, they are to find out if developments in the nature of provision were responsible for the changes in service use, and whether changing service use resulted in alterations in contraceptive effectiveness.

1.2 The Family Planning Services

The principal services concerned are:

Family planning clinics provided by Area Health Authorities mainly on multi-purpose health premises or by hospitals, and General Practitioners.

In addition contraceptive advice and supplies may be given in hospitals to maternity and abortion patients, and on domiciliary visits arranged by Health Visitors.

The main methods of contraception available from the services are oral contraceptives and IUD's, and these 'medical' methods can be obtained only through the services or from a private doctor.

Sterilisation may also be advised by the services and is carried out in hospitals, at hospital out-patient clinics or in other suitable accommodation provided by Health Authorities or voluntary agencies.

Until 1968 family planning (contraceptive advice and supplies) was not provided by the National

Health Service, except for women who had a medical need to avoid pregnancy. Instead it was available from general practitioners (GPs) and voluntary organisations, such as the Family Planning Association (FPA).

The Family Planning Act of 1967, implemented from 1968 enabled Local Health Authorities to provide contraceptive advice to all who asked for it regardless of medical need or marital status. The Authorities were urged to provide free advice but to charge for supplies except in cases of medical need.

Most of the Local Health Authorities which made use of their powers under the Act used the FPA as agents. Following the reorganisation of the NHS in 1974, when Local Health Authorities were replaced by Area and Regional Health Authorities, arrangements were made for the transfer to the National Health Service of all clinic services provided by the FPA on an agency basis.

General practitioners remain free to choose whether they will provide a family planning service, but guidance from the Department of Health and Social Security makes it clear that they can regard this as a proper part of their role under the NHS.

Contraceptive supplies of any kind including 'non-medical' methods prescribed and dispensed through clinics became free of charge on 1 April 1974. Those prescribed by general practitioners and the prescriptions for them did so on 1 July 1975. Charges remain for supplies of 'non-medical' contraceptive methods (primarily the sheath) if obtained from clinics but without professional consultation.

At the same time as the NHS began to assume responsibility for family planning services, the Abortion Act of 1967 greatly widened the legally permissible grounds for abortion, and the numbers of abortions performed within the NHS correspondingly increased. Female sterilisation has been provided under the NHS on medical grounds since the inception of the service, but became explicitly available for family planning reasons in 1974. Vasectomies for contraceptive reasons were offered under the NHS from November 1972.²

¹Bone, M, *Family Planning Services in England and Wales*, HMSO 1973.

²DHSS Circular 44/72 of 8.11.72.

The last decade, then, has seen a transition from a chargeable service dependent on voluntary organisations and the inclination of individual general practitioners to a free one for which the government through the National Health Service has assumed complete responsibility. The change has come about during a period of concern about population growth, but the aim of the family planning services throughout the transition has been to enable people to avoid unwanted pregnancies and not to influence population change.

1.3 The 1970 survey of family planning services

The first national survey of the use of the services was carried out for the Department of Health and Social Security in the wake of the 1967 Family Planning Act. Its broad purposes were to assess the adequacy of the existing services and to suggest some of the ways they might usefully develop to ensure that everyone who needed contraceptive advice could obtain it without difficulty. To collect the necessary information representative national samples of married women under 41, and of single women aged 16-35 were interviewed about their experience, and views of the services and of contraception.

The main conclusions drawn from the findings had to do with the nature of unmet need for contraceptive advice at the time and the deployment and kind of services which seemed necessary to provide for the people concerned. Some of the relevant evidence will be referred to in the course of the present report and what follows is a brief sketch of the situation found in 1970.

A quarter of the married women were making use of the services but almost all those 'at risk'—neither sterile nor pregnant or trying to conceive—were using or their husbands were using some form of contraception and a quarter were using the pill. A third, however, were using methods, like withdrawal, which are relatively unreliable; unplanned pregnancies were not uncommon and one-sixth of the pregnancies occurring in the year preceding interview had been unwelcome.

Only 6 per cent of single women were using the services although about a quarter said they had experience of contraception, including 9 per cent who had used the pill.

It appeared that use of the family planning services and of the pill were growing over the generations amongst married women, but there was no evidence from the survey of trends amongst single women.

1.4 More about the objectives of the 1975 survey

In 1975 the DHSS wanted information not only

about women similar to those interviewed in 1970; that is, ever-married women aged 16-40 and single women aged 16-35—the most fertile—but also about all women capable of conception and therefore eligible to use the services. Their interest in this information arose in part from their need to know about the extent and relevant behaviour of the entire potential service clientele, but also from a concern with the situation of older women—those who are unlikely to welcome further pregnancies, who are approaching the menopause and who may have special difficulties in using the services. In practice, ever-married women aged 16-55 and single women aged 16-40 were sampled.

More generally, one of the aims of the survey is to identify groups of women whose need for effective contraception remains unmet and, in addition, to indicate aspects of the services which appeared to be unsatisfactory in 1975.

Viewed in the context of changes since 1970, the 1975 situation should provide some guidance not only to what still needs to be done, but to what does *not* need to be done, because, for example, a group particularly prone to unwanted pregnancy is rapidly diminishing, or because what seemed in 1970 to be an unsatisfactory aspect of provision appeared in retrospect to be no hindrance to service use.

The second group of objectives, which concern the effect of administrative changes in the services on use, and of service use on contraceptive practice, are not merely of historic interest. Our main purpose here is to derive information about the effectiveness of the family planning services in the recent past which will be of value to policy-makers and administrators in deciding how the services should develop in the next few years.

1.5 The demographic background

In the late 1950s the fertility rate in England and Wales rose to reach a high point in 1964. Since the early 1960s in common with that of other western countries it has declined, and particularly steeply since 1970. The initial upsurge is attributed to the interaction of earlier marriage, shorter intervals between births and larger completed family sizes. The subsequent decline is accounted for by a reduction in fourth and later births and by the postponement of first births or an increase in childlessness. These changes in turn are usually held to be the result of underlying social and economic forces although the mechanisms involved have not yet been demonstrated.

On this view, birth control plays only an instrumental role in determining fertility trends, by enabling people to approach their fertility targets more or less accurately, whilst the development of

modern birth control techniques and of their system of distribution (here the family planning services) are seen as largely responses to the same forces which brought about the decline in fertility. The special feature claimed for modern techniques is that compared with traditional methods they enable people to control their fertility to desired levels with great precision. This is exactly the role which the family planning services, as the exclusive source of these methods, are intended to play and it is in this context that the effectiveness of the main service-supplied methods is examined in this report.

On the other hand, the notion of services as ancillary raises the question of whether it is sensible to look for any effects of changes in the way services are provided on use of those services, if in fact it is changes in demand which influence provision.

The view on which the first part of the report is based is that even if the assumptions are right, in the short term it is at least possible that improvements in the services increase use by inducing or enabling people, who otherwise would not, to use them and so to practice effective contraception. The impact if any should be greatest on groups like those who marry young who have historically lagged behind others in successful family planning, and on older women who have become accustomed to traditional methods. The general effect to be expected of good services is a reduction in differences between groups in the practice of effective contraception, even though other factors, like improved education, may also be involved.

In addition the view of modern birth control techniques as ancillary to the recent fertility decline in the west has not gone unchallenged. The protagonists of an alternative interpretation maintain that throughout the twentieth century couples have aimed for families of two children only and that 'the principal explanation for the (recent) decline (in fertility) is the substantial improvement in the ability to regulate fertility'.^{2,3}

The argument refers to the situation in the United States, but if applicable there might be equally so in England and Wales. This interpretation appears to allow a more influential role for the family planning services, and for more than marginal effects of service improvements on use.

Both views, however, acknowledge the primacy of people's desire for smaller families in bringing

about the decline in fertility. And indeed it is obvious that neither the new methods of contraception nor any of the systems for their distribution (e.g. the family planning services) could have caused the decline unless people had wanted fewer children than had been born to their predecessors.

1.6 Method

Because one of the main objects of the 1975 enquiry was to show changes in service and contraceptive use since 1970, it was necessary to use the same method of investigation: a national interview survey of representative samples of women in the relevant age ranges and living in England or Wales.

New samples were drawn in 1975 because of the need to include women who had become 16 after the 1970 survey as well as women up to the age of 55.

In 1970 it was possible to infer changes in service and contraceptive use by comparing the experience of women married at different periods. For example, if a greater proportion of those married in the preceding 5 years than of others married earlier have ever used the pill, this indicates increasing use over the generations and, by implication over time. Groups of people who were married or born or experienced some other key event during a defined calendar period are known as 'cohorts' or sometimes 'generations', although the last term has a looser meaning in everyday speech.

The same method of cohort analysis is used again in the 1975 survey to show how behaviour has changed within and between generations, but this was supplemented by information collected from the married women about their pregnancy and contraceptive histories.

Taken altogether, the information obtained in the two surveys shows: what changes occurred between 1970 and 1975; whether these are due to successive generations behaving differently from their predecessors or to changes in the behaviour of every generation from one time to another; and finally, trends in behaviour over the much longer period covered by the married lives of all the women in the 1975 survey.

1.7 The sample design

a. The target populations In 1970 the samples were confined to women in the most fertile years and were of ever-married women aged 16-40 and single women aged 16-35.

In 1975 we wished to include not only women comparable to those represented in 1970, but also

²N B Ryder—The family in developed countries—*Scientific American* 231, No. 3 (Sep 1974).

³The view is contended by Judith Blake and Prithwis Das Gupta in *Reproductive Motivation versus Contraceptive Technology: is recent American experience an exception?—Population and Development Review—December 1975, 229-249*. The authors provide bibliographies for the two theses.

all women who might be able to conceive and therefore potentially in need of contraception.

Accordingly, the ideal target populations would have been ever-married women aged 16-55 and single women aged 10-55; in the first case from the earliest legal age of marriage to the age by which almost all women have passed the menopause, and in the second from about the earliest age of menarche until, again, the fecund years have passed.

In practice, the samples were of ever-married women aged 16-55, as was desirable, but of single women aged 16-40.

Single girls under 16 were omitted because of the difficulties foreseen in interviewing young girls on the subject, whilst those over 40 were excluded because of their rarity.

b. The samples The original intention was to include the same number of women in the age groups covered in 1970 as were obtained then, together with proportionate numbers of older women, but in the event, the prevailing need for economy restricted numbers to less than the original target. The numbers of interviews finally achieved were:

ever-married women aged 16-55	3898
single women aged 16-40	749

No sampling frame exists for the populations concerned and it was therefore necessary to draw a random sample of addresses sufficiently large to yield the required numbers of interviews, taking into account the prevalence of the eligible women in the general population and the estimated response rates. It was calculated that 11,000 addresses were required, and the eligible women living in them were located by a postal enquiry.

The sample of addresses, intended to give every woman in the target populations an equal chance of selection, followed a 3 stage stratified design. At the first stage New Districts were grouped according to the Standard Region to which they belonged and whether they were metropolitan districts or not. Within each resulting group the constituent districts were arranged in descending order of population size and 99 districts were then selected with probability proportional to size. At the second stage 4 wards⁴ were drawn from each selected district with probability proportional to the size of the electorate, and at the third stage a sample of approximately 11,000 addresses was systematically drawn from the sampled wards.

A postal questionnaire and covering letter were sent to each of the selected addresses (followed where necessary by two reminders) and women

⁴Or groups of wards for those containing less than 2,200 electors.

eligible for interview were identified from the completed forms. The reduction in the original set sample size was made by rejecting systematically 1 in 6 of the women identified.

The response rate to the postal enquiry about the numbers, ages and marital states of those living at the sampled addresses was 87 per cent. Interviewers visited each of these selected addresses and sought interviews with every resident eligible woman. Half of the addresses from which there was no response to the postal enquiry were also visited by interviewers, whose task in these cases was to identify as well as to interview eligible women.

Usable interviews were achieved for 86 per cent of all the ever-married women and for 76 per cent of all the single women identified as eligible.

A full account of the sample design and of the response rates to the postal and interview stages are given in Appendix II.

1.8 The interviews

Information was collected from the sampled women by personal interview using the structured schedules shown in Appendix I. For married women, these cover not only the women's socio-economic and demographic circumstances, their experience and views of the services and use of contraception, as in 1970, but also, their pregnancy and contraceptive histories.

For single women, the questions asked were for the most part identical with those used in 1970. It was again felt that the time was not ripe to question single women, and particularly the younger ones, directly about their sexual experience.⁵

Because many of the questions included in the schedule had not been used in 1970 and a few of those used in 1970 were changed slightly in order to improve them, the 1975 schedule was tested in a small-scale pilot survey of women at 100 addresses, which produced 45 interviews with married women and 11 with single women. Further modifications were introduced as a result of the interviewers' experience and the subsequent coding operation.

The main fieldwork was carried out between 23 June and 15 August 1975.

1.9 The plan of the report

One way of presenting the findings of the 1975 survey would have been to adopt the same plan as

⁵In the following year, 1976, such questions were successfully introduced for single women into the Family Formation Survey carried out by K. Dunnell of Social Survey Division, OPCS (in progress).

was used in the Report on the 1970 enquiry, adding sections on the non-comparable material—that is, in the manner of regular publications of routinely collected statistics. But because one of the main concerns of the Report is with the nature and consequences of changes in service use, it seemed more appropriate to follow this theme, introducing comparisons between the 1970 and 1975 material where they form a natural part of its development.

The report falls into four parts, of which the first three relate to ever-married women and the fourth to single women.

The first part (Chapters 2 to 4) deals only with women under 41, those comparable with the women covered in 1970. Here we trace the way service use had changed (Chapter 2), the way this change seemed to be related to innovations in provision, including which features still seemed unsatisfactory (Chapter 3) and the accompanying changes in contraceptive use (Chapter 4).

The second part (Chapters 5 and 6) is concerned with the situation amongst the 16–55 year olds in mid-1975 and the position of the older women amongst them, but the theme of change recurs throughout the analysis. In Chapter 5 we deal with the extent of exposure to risk of unintended conception and the way this is changing over time, and then go on to look at use of the services and of contraception for those at risk in the entire age range and how the older women differed from the younger ones, including any special difficulties experienced by older women (Chapter 6).

Chapters 7 to 12, which are based on the contraceptive and pregnancy histories, are about the way in which the service-provided methods are related to the practice of effective contraception and, in turn, to pregnancy rates.

Chapters 13 to 15 deal with single women in a similar way, but more briefly, and omit an examination of the consequences of changing service and contraceptive use.

2 Changes in the use of family planning services between 1970 and 1975

2.1 The change which had occurred

The results of the 1970 and 1975 surveys together reveal a considerable increase in the proportion of women using the services over the period. This appears very clearly when the experience of ever-married women under 41 years in 1975 is shown beside that of those under 41 in 1970. The most relevant difference is in *current* use of the services by women at risk of an unintended pregnancy (those who were fecund and neither pregnant nor trying to conceive).¹ In 1970, 31 per cent of such women were currently using the services, compared with 51 per cent in 1975 (Table 2.1). At the same time, whilst the proportion of women who had *ever* used the services had increased from 57 per cent to 74 per cent, the percentage who had used them in the past but who were currently not doing so had slightly decreased from 26 per cent to 23 per cent. In other words, it appears that not only had use increased, but also that it had become more persistent. In the absence of individual histories of service use, however, this interpretation of the figures is somewhat speculative.

2.2 Definitions

A service user is defined here as a woman who receives practical advice on contraception at a

¹The way in which the proportions of women at risk is changing is examined in Chapter 5.

family planning or other clinic (e.g. post natal clinic), from her general practitioner or some other doctor, or on a maternity ward.

A 'current user' is, with minor qualifications, defined as a woman who:

- has received contraceptive supplies, prescriptions or practical advice from one of these services within the year preceding interview, and
- explains her lack of contact with the services since her last visit as due to its not being time for her next visit.

'past users' are all other women who have received contraceptive supplies, prescriptions or practical advice from one of these services.

'ever users' are current and past users combined.

'never users' are those who have never received contraceptive supplies, prescriptions or practical advice from one of the services above.

2.3 The trend in use of the family planning services

Between 1970 and 1975 a radical change in provision occurred, and since we shall later be looking at its impact on service use, it is important to know whether the increased use between the

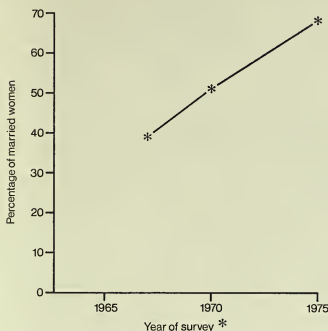
Table 2.1 Use of the family planning services, 1970 and 1975, ever-married women under 41

	All women		Fecund women		Fecund women not pregnant nor trying to conceive	
	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%
Use of services:						
Current GP user	14	19	16	23	18	26
Current clinic user	9	16	10	19	12	21
Current other doctor user*	1	2	1	2	1	2
Current other user*	NA	..	NA	1	NA	1
Total current users	24	37	27	44	31	51
Past users	27	31	28	29	26	23
Total ever users	51	68	54	73	57	74
Never users	43	32	44	27	42	26
Not known	6	..	1	..	1	..
Base: ever-married women under 41 = 100%	2,520	2,344	2,241	1,913	1,895	1,655

*Because the proportions of women currently using 'other doctors' or 'others' (ie non-physicians at clinics or attached to a general practitioner) these two categories are amalgamated in subsequent tables.

two years represented a continuation of an existing trend or not. Unfortunately, no exactly comparable evidence is available for any earlier year, but a survey carried out in 1967 provides figures for ever use of professional advice (Langford, 1976).² Taken together with the percentages of ever users of the services in 1970 and 1975 the three figures suggest a continuous upward trend in ever use from at least 1967 onwards, with no indication of an acceleration after 1970 (Fig. 2.1). The compo-

Figure 2.1 Trend in ever-use of the family planning services between 1967 and 1975



Note: See text for comparability of the samples in the three years.

sition of the 1967 sample differs somewhat from those of 1970 and 1975, but figures for the women married between 1951 and 1965 in the 1967 enquiry should be roughly comparable with those for the later years.³ They show that about 39 per cent of these women had ever received professional advice in 1967, compared with 51 per cent in 1970 who had ever used the services, and 68 per cent in 1975. The detailed analyses of both the 1967 and 1970 surveys imply that the initial upsurge in service use occurred at about the time of the general introduction of the pill (1961).

²C M Langford, *Birth Control Practice and Marital Fertility in Great Britain*—Population Investigation Committee, London 1976.

³The 1967 sample was of women under the age of 61 who had been married only once before the age of 35 during 1941–1965 inclusive and includes some living in Scotland. Since the great majority of women marry before the age of 30, few of those who married in 1951 or later would have been over 46 in 1967. C M Langford, *op cit*, p 3 and p 7.

2.4 Changes by year of marriage

The findings of the 1970 survey indicated that use of the services was increasing over the marriage cohorts (or generations), except that those married in the 4½ years preceding interview were rather less likely than their immediate predecessors to be using the services.⁴ A relevant question about the increased uptake since 1970 is therefore whether it has been due to a continuation of this trend—a tendency for successive marriage cohorts to make more use of the services than those who came before—or whether it has resulted from greater use by every marriage cohort. The answer as will be shown seems to be both: the proportion using the services continues in 1975 to increase with year of marriage, but at the same time use by each cohort is greater than for the same cohort in 1970. The demonstration of these changes introduces a complication into the analysis. A comparison of the experiences of the same marriage cohorts in 1970 and 1975 for women aged under 41 in each year is misleading as evidence of change within cohorts over time, because it involves comparing different women's experience at different times, rather than the same women at different times. This is because the under 41 year old representatives of each marriage cohort interviewed in 1975 will, on average, have married younger than the under 41 year old representatives of the same cohorts interviewed in 1970. For example, a woman who married at the age of 25 in 1956 would have been included in the 1956–60 cohort in 1970, because she would then have been under 41, but she would have been excluded from the same marriage cohort in 1975 because by then she would have been more than 41 years old. In order, then, to show changes *within* marriage cohorts over time it is necessary to compare representatives of the same *age* cohort at the two time points. Accordingly Figure 2.2(a) shows current use of the services by women under 41 in 1970, together with that of women aged under 45 in 1975.⁵ It illustrates clearly the way in which current use of the services has increased amongst every marriage cohort except the earliest (married during the years 1951–56) since 1970 (see also Table 2.2). An incidental point emerging from the comparison of the two years is that the unusually steep increase in the proportion of users between the 1956–60 and 1961–65 cohorts visible in 1970, and ascribed to the introduction of the pill, was no longer evident in 1975. The imprint of this event on a specific

⁴M Bone *Family Planning Services in England and Wales* HMSO 1973, p 14, table 2.2.

⁵The comparable group for the under 41 year olds in 1970 is the under 46 year olds in 1975. The age data had already been arranged in 5-year groups before the necessity for this mode of comparison became evident. In addition, the 1970 cohort will have been depleted by some sterility by 1975. The addition of the 41–45 year olds, of course, does not directly account for changes amongst the under 41s in each year but helps to show that the increases within generations are not solely due to their changed composition in terms of age at marriage.

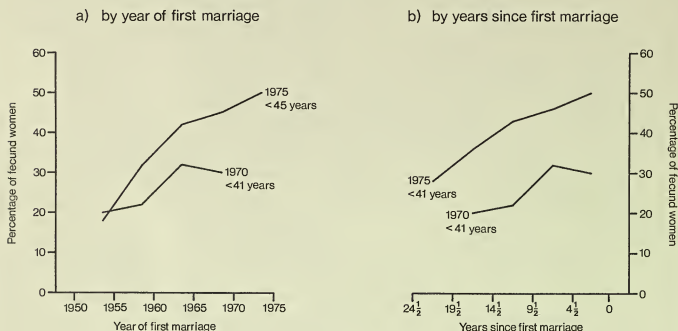
marriage cohort had faded with the passing of time.

Generational differences amongst women under 41 in 1975, however, are of interest in their own right, and can in fact be compared with those amongst women aged under 41 in 1970 by viewing each group not as marriage cohorts but as women who had been married for different durations, so that the experience of those who had been married between, say 0 and $4\frac{1}{2}$ years before interview in

In summary, current use of the family planning services by ever-married fecund women increased between 1970 and 1975 and this was both because women who had married in successive periods made more use of the services than their predecessors, and because those married at particular periods were more likely to use the services in 1975 than in 1970.

Of particular interest is the evidence that, unlike in 1970, in 1975 those married during the $4\frac{1}{2}$ years

Figure 2.2 Current use of family planning services, 1970 and 1975



1970 can be compared with that of women married for the same number of years in 1975.⁶

Figure 2.2(b) shows use of the services amongst women under 41 in 1970 and 1975 according to the time since their first marriage. It can be seen that for every period since first marriage use was higher in 1975 than in 1970. In particular, for the later year alone the proportion of women currently using the services consistently increases the more recent the marriage, so that, unlike in 1970, those married during the $4\frac{1}{2}$ years preceding interview were more likely than any other women to be using the services (see also Table 2.3). In 1975 50 per cent of the fecund women married after 1970 were currently using the services, but amongst those in the group who were at risk of unintended conception at the time of interview 64 per cent were doing so.

⁶The marriage durations used are 0- $4\frac{1}{2}$, -9½, -14½ years, etc, because they are derived from the year of marriage, and because interviews took place in mid-1975.

before interview were more commonly service users than their immediate predecessors, indicating that the services are now increasingly used by women in the earliest years of marriage, a point which receives some corroboration from the material on contraceptive history in Chapter 7.

2.5 Changes and social class

In 1970 a higher proportion of the wives of non-manual than of manual workers made use of the services, and the wives of semi- and unskilled workers were the least likely of all to be service users. The difference between the non-manual and manual groups appeared to be largely, although not only, due to differences amongst the most recently married. This was taken to mean that the manual group turned to the services at a later stage in marriage than other women. Since there is no reason to suppose that the wives of manual workers have less need for the services than others, one measure of progress since 1970 would be the

Table 2.2 Use of the family planning services 1975, by ever-married women aged under 45 years, according to year of marriage*—fecund women only

1975	Year of marriage					
	All years	1951-55	1956-60	1961-65	1966-70	1971-75
	%	%	%	%	%	%
Use of services:						
Current GP user	21	12	19	22	22	24
Current clinic user	17	4	11	18	21	22
Current other user	2	2	2	2	2	3
All current users	40	18	32	42	45	50
Past users	29	26	26	23	32	33
Total ever users	69	44	58	65	77	83
Never users	31	56	41	35	23	17
<i>Base: ever-married fecund women <45 = 100%</i>						
	2,220	225	404	436	597	522

*See note to Table 2.3.

Table 2.3 Use of the family planning services 1975, by ever-married women under 41 years, according to year of marriage*—fecund women only

1975	Year of marriage					
	All years	1951-55	1956-60	1961-65	1966-70	1971-75
	%	%	%	%	%	%
Use of services:						
Current GP user	23	24	22	22	22	24
Current clinic user	19	2	12	18	21	22
Current other user	2	2	2	2	2	3
Total current users	44	28	36	43	46	50
Past users	29	19	27	23	32	33
Total ever users	73	47	63	65	78	83
Never users	27	53	37	35	22	17
<i>Base: ever-married fecund women <41 = 100%</i>						
	1,913	53	316	425	592	522

*Because of the upper age limit there is an age at marriage bias, i.e. the women married in the earlier periods were necessarily younger at marriage on average than those married in the later periods.

diminution of differences between the social classes.⁷

In fact, between 1970 and 1975 use of the services by every social class group had grown considerably, so that a greater proportion of Class IV and V wives in 1975 than of non manual wives in 1970 were current users (39 per cent compared with 32 per cent). But despite this general increase, the difference between the social classes persisted, and the wives of semi- and unskilled workers remained the least likely to be service users (Table 2.4(a) and (b)).

⁷The wives of manual workers are more likely than other wives to be pregnant at marriage and it could therefore be that they are less in need of contraceptive advice in the first months of marriage. Similarly the increased use of the services by manual workers' wives in the first years of marriage between 1970 and 1975, could be attributed to the reduction in pre-maritally conceived live births which occurred between the two years (see *Population Trends* No 7, HMSO 1977). It will be shown in Chapter 12, however, that amongst women who were not pregnant at marriage the proportion of manual workers' wives who use contraception before their first pregnancy has been lower than amongst other wives for many years. It is therefore true that there is no reason to believe that in the first years of marriage, any more than at other times, the wives of manual workers have less need for the services than other women.

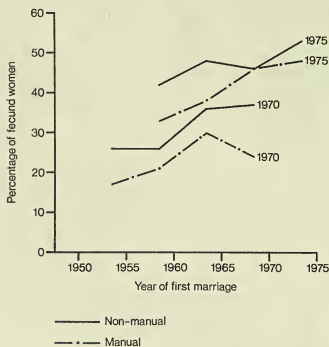
There was, nevertheless, some indication of a change in the situation. Firstly, it appeared that use of the services by the manual group had grown slightly more rapidly than use by other women, that is by 75 per cent compared with less than 50 per cent, although the differences could be due to sampling errors. Secondly, in 1975 the difference between the classes in the extent of service use narrowed considerably amongst women married from 1966 onwards. Moreover, unlike in 1970, the most recently married of the manual group made more use of the services than their immediate predecessors, a pattern already evident for the non-manual group in 1970 (Fig. 2.3). The most striking instance of the narrowing of class differences over the generations occurred between the non-manual group and those in Classes IV and V: for women married from 1971 or later, there was a negligible difference between these two groups in the proportions who were current service users—about 52 per cent (Table 2.5).

There is, then, suggestive evidence that the difference between the social classes in service use is diminishing and that the special tendency of the

Table 2.4 Use of the family planning services by social class—ever-married fecund women under 41 years

	Social Class				
	All classes	Non-manual	Manual		
			III	IV & V	Total
(a) in 1975	%	%	%	%	%
Use of services:					
Current GP user	23	23	23	22	23
Current clinic user	19	22	18	14	17
Current other user	2	2	2	4	2
Total current users	44	47	43	40	42
Past users	29	33	27	25	26
Ever users	73	80	70	65	68
Never users	27	20	30	35	31
Base: ever-married fecund women under 41 = 100%	1,913	764	828	321	1,149
(b) in 1970					
Use of services:					
Current GP user	16	15	17	12	16
Current clinic user	10	15	7	8	7
Current other user	1	1	1	1	1
Total current users	27	32	24	21	24
Past users	28	30	26	27	27
Ever users	54	62	51	49	50
Never users	44	36	48	51	49
Not known	1	2	..	..	..
Base: ever-married fecund women under 41 = 100%	2,241	788	994	421	1,415

Figure 2.3 Current use of the family planning services by social class in 1970 and 1975 (fecund women under 41 years)



manual group to postpone seeking advice until after the early years of marriage is disappearing.

2.6 Changes in the service outlets used

Up to this point the focus has been on changes in

use of all services, but trends in the use of specific outlets are also of interest because of the DHSS decision in 1974⁸ to foster a choice of services—GPs or clinics in various settings—rather than to promote one at the expense of another. A relevant question, therefore, is what use women have made of this choice. In fact, one major innovation in provision, the introduction of free services, became effective for clinics earlier than for GPs, through whom services became free only during the 1975 interviewing period. On this account, clinics had been more available than GPs from the cost point of view for part of the period between 1970 and 1975. The ultimate effect of this development on the type of outlet used would not be evident from the 1975 survey.

Use of both GPs and clinics had increased between 1970 and 1975, GP use remained rather more common than clinic use, but there was some evidence from the experience of the total samples that use of clinics was increasing more rapidly than that of GPs (by 90 per cent and under 50 per cent respectively) although this apparent narrowing of the difference could be due to sampling errors (see Table 2.1). It appeared, moreover, that amongst the women married after 1965 clinics were almost as popular as GPs as sources of advice (see Table 2.3). On the assumption that these differences between the marriage cohorts reflect latent time trends, it appears that clinic use was becoming as common as GP use.

⁸Health Service Circular (interim series) (15) 32, May 1974.

Table 2.5 Use of the family planning services by social class and year of marriage—ever-married fecund women under 41 years

1975	Year of marriage and social class											
	1956-60				1961-65				1966-70			
	Manual		Non-manual		Manual		Non-manual		Manual		Non-manual	
	III	IV & V	III	Total	III	IV & V	III	Total	III	IV & V	III	Total
Use of services:	%	%	%	%	%	%	%	%	%	%	%	%
Current GP user	24	18	21	23	24	21	21	23	24	23	26	24
Current clinic user	16	6	10	14	14	12	14	14	21	17	24	22
Current other user	2	3	2	1	1	2	2	1	2	2	3	4
All current users	42	27	33	48	39	34	38	46	46	44	53	52
Past users	31	25	25	20	20	19	20	35	29	32	36	34
Ever users	74	52	58	58	60	54	58	81	75	75	89	76
Never users	26	48	42	42	40	47	42	19	25	24	11	23
Base: ever-married fecund women under 41 years = 100%	102	63	214	194	173	58	231	249	254	89	203	343
	151										228	91
												319

As in 1970, an identical proportion of the wives of manual and non-manual workers were current GP users in 1975, but a rather greater percentage of the non-manual than of the manual group were clinic users. A comparison of figures for the two years suggests use of clinics alone may have been growing most rapidly amongst the wives of manual workers. That is, between 1970 and 1975 clinic use by the non-manual group had increased by about 50 per cent, but by almost 150 per cent amongst the manual group. Use of GPs by both groups had grown by around 50 per cent (see Table 2.4). This evidence receives some support from the inter-generational patterns of use by each social class, which reveal that clinic use by the manual group uniquely increased continuously with the period of marriage (see Table 2.5). It is therefore possible that not only the differential use made of any family planning services by the two social classes, but also of specific outlets, was diminishing between 1970 and 1975.

2.7 Para-medical provision

Since 1970 there has been a growing interest in the non-physician supply of contraception through the services and for this reason the 1975 informants were asked whether they had ever received contraceptive advice or prescriptions at a clinic or their doctor's surgery from a nurse or anyone else without ever seeing the doctor about it. The answers intentionally exclude those who saw a doctor at the first of a series of visits but who subsequently dealt with someone else. It is possible that some clinic clients who were never seen by a doctor mistakenly supposed that the person who provided advice was a doctor, and the 1 per cent of women who are shown to be receiving advice from non-physicians through the services in 1975 (Table 2.1) may therefore be an underestimate.

2.8 Summary

Use of the family planning services by ever-married women under 41 had increased considerably between 1970 and 1975. The change was due both to the greater use made of the services by successive marriage cohorts of women than by those who came before, and to an increase over time in use by every marriage cohort. Unlike in 1970, there was no indication that people postponed service use until after the early years of marriage. In 1975 the most recently married were more likely to use the services than their predecessors.

Service use appears to have grown rapidly at least since 1967, and it seems possible that the present trend began at about the time of the general introduction of the pill in 1961.

As in 1970, the wives of non-manual workers in 1975 were rather more likely than other women to use the services, but there were indications that this situation was changing. It may be that in the near future service use will be at least as common amongst the manual as amongst the non-manual group.

GPs remained rather more popular than clinics in 1975, and use of both these major outlets had grown between the two survey years. There was, though, suggestive evidence that the difference was narrowing and that this was largely due to the greater use made of clinics by successive generations of manual group wives.

3 Changes in the services since 1970, and remaining deficiencies

3.1 Introduction

The purposes of this chapter are two. In the first place we shall try to discern the impact of administrative changes in the provision of services upon the use made of them, and on the way users experienced them; in the second, we shall look at features of the services which may still inhibit more extensive use amongst potential clients. The two questions are dealt with in different sections of the chapter but there is inevitably an overlap of subject matter, since discussion of change itself indicates where there is scope for further improvement, whilst the relative importance of prevailing deficiencies becomes clearer in the context of change.

3.2 Changes in provision

How far the increase in service use between 1970 and 1975 was due to changes in provision is a question of practical interest, since the answer will have implications for the future deployment of resources. But it is a question extraordinarily difficult to answer.

The evidence is that service use was already increasing before 1970 and it would perhaps have continued to do so even had no innovations subsequently occurred in provision. In addition, there have since 1970 been developments other than in the services which may have stimulated people's demand for effective contraception—the economic recession, for example, the public attention given to population growth, and so on. In these circumstances it is probably impossible to identify with any certainty any specific role of improvements in the services. All that can be done is to show how these have impinged on actual and potential clients, and to indicate where the patterns of changing use were those to be expected had they been brought about by the service innovations.

(a) *Cost* The fundamental change in provision between 1970 and 1975 was the abolition of all charges for contraceptive advice, prescriptions and supplies obtained through the services. The last remaining charges for clinics were removed on 1 April 1974, and for GPs on 1 July 1975. In the latter case, this was during the period when the 1975 sample women were being interviewed.

If this innovation induced more women to use the services after 1970, the effect should be evident only

for clinic use. This is both because of its earlier application to clinics, and because clinics, it seems, were formerly more likely than GPs to charge for contraceptive services.¹ The impact, moreover, should be greatest for sections of the community who were earlier most inclined to see service use as expensive, for example the wives of manual workers.² Explicitly, we should expect to find that clinic use increased more steeply than GP use between 1970 and 1975, and that this was due to a sharper rise in their use by the manual than by the non-manual group.

It was shown in the last chapter that there is some evidence that clinic use grew more rapidly between 1970 and 1975 than GP use, and that use of clinics by manual workers' wives showed a steeper increase than their use of GPs or than the use of clinics by other women. The spurt in the popularity of clinics appeared to be continuing at the time of the 1975 survey because, although more or less similar proportions of each marriage cohort were obtaining advice from GPs in 1975, increased proportions of successive cohorts were doing so from clinics, and this was most consistently the case for the wives of manual workers. There is therefore suggestive, but by no means conclusive, evidence that the removal of charges had influenced use between 1970 and 1975.

One reason for the absence of any dramatic impact of this innovation is implied by a finding of the 1970 survey. At that time nearly 80 per cent of those who had never used the services did not know whether clinics made a charge, and nearly 70 per cent were similarly ignorant about the GP service.³ For these women it seemed that the cost could not have been a deterrent to use. It may be, nevertheless, that the sure knowledge that services are free encourages use, and a question of interest here is how wide-spread such knowledge was in 1975. Table 3.1 shows that about a quarter of all fecund women and of never users believed that at least one item of the clinic service was not free and that over 40 per cent of all the fecund women and 66 per cent of never users did not know whether the service was completely free. In the case of GPs, when charges were abolished there was some reduction in the proportions both of all fecund

¹M Bone—*Family Planning Services in England & Wales*, London HMSO, 1973, p 38.

²M Bone *op cit*, p 44.

³M Bone *op cit*, p 38.

Table 3.1 Women's knowledge or belief that family planning services were free

	Clinic	GP	
		Before July 1975	July 1975 and after
Advice or prescription or supplies	%	%	%
a. All women			
thought <i>not</i> to be free	23	59	47
not known if free	44	46	46
Base: all fecund women 16-55 = 100%	2,673	415	2,258
b. Never users			
thought <i>not</i> to be free	26	45	39
not known if free	62	67	63
Base: all fecund never users 16-55 = 100%	983	139	844

Note: There is some overlap of those who believed at least one item not to be free and those who did not know whether at least one item was free or not, because a woman might believe supplies, say, to be not free but be uncertain about advice. For this reason some of the columns add to more than 100%. Women who believed all three items to be free are omitted.

women and of never users who thought the service was not completely free. Even so, approaching half of the women and nearly 40 per cent of never users continued to believe there was a charge after the end of June 1975. The decline in the proportion of either group who were ignorant of what the situation was, was negligible.

(b) **Accessibility and availability** Since 1970 the number of service outlets in England and Wales has increased. In particular, the number of clinics rose from 1,385 in 1971 to 2,161 in 1974.⁴ The change in the number of GPs willing to provide contraceptive advice is unknown, but it is probable that this too has grown.

During the same period (1971-74) the population of women aged 15-44 increased from 9,325 to 9,479 thousands,⁵ which means that in 1971 there was, on average, approximately one clinic for every 6.7 thousand women, compared with one for every 4.3 thousand in 1974.

This evidence from routinely collected statistics implies that, other things being equal, clinics at least should be easier than formerly to use, because they can be reached more quickly or because visits are less time-consuming or because both improvements in accessibility have occurred. This has been the intention of the Department of Health and Social Security who in 1974 urged Health Authorities to provide clinic facilities close to people's homes, within easy reach of public trans-

port and open at convenient times and at several places in a district.⁶

The effects on use to be expected of this development are similar to the ones supposed for the removal of charges. Clinic use should have increased more sharply than GP use because GPs were already relatively accessible in 1970,⁷ and the wives of manual workers should have been more encouraged than others, because they were less likely to have the private transport often formerly needed for clinic, in contrast to GP, visits.⁸ As recalled in the previous section on cost, it is possible though not certain that these patterns of change were occurring.

It is worth finding out at this point whether clinics actually seemed more accessible to women in 1975 than in 1970. A rather higher proportion of women in 1975 than in 1970 said they knew of a clinic within half an hour's reach (65 per cent compared with 53 per cent) but this was reflected less by a decline in the proportion who reported the lengthiest journey times than by a reduction in the proportion who either did not know the whereabouts of a clinic or else how long it would take them to reach the nearest one (Table 3.2).

Table 3.2 Actual or expected journey time to clinic—1970 and 1975

Journey time	1970 1975	
	%	%
Under ½ hour	31	38
½ hour —	22	27
½ hour —	15	12
1 hour or more	3	2
Don't know either length of journey to or location of clinic	28	17

Base: Ever-married women under 41 who were fecund, or who were sterilised but had used clinic* = 100%

2,316 2,130

*The unusual base is used because of difficulty in retrieving figures for fecund women only from the 1970 survey.

What is unknown is the extent to which ignorance of a clinic's whereabouts was due to the absence of a local clinic, to inadequate publicity, or to a lack of interest in the information provided. But at least it is clear that rather more women in 1975 than in 1970 actually knew of a relatively accessible clinic.

The impact of known improvements in the services on their availability for women as a whole is generally difficult to detect when there have been concurrent changes in the extent of knowledge.

⁴DHSS statistics SR4. Figures refer to premises used regularly for family planning sessions.

⁵Population Trends, London (HMSO), 5, Table 16, p. 44. The ratios of clinics to currently married women similarly changed from 1 : 4.6 thousand in 1971 to 1 : 3.0 thousand in 1974.

⁶DHSS—Health Service Circular 4—(Interim Series) 32—Memorandum of Guidance—1974.

⁷M Bone—Family Planning Services in England & Wales, London, HMSO 1973, p. 37.

⁸M Bone *op cit*.

For this reason it is useful to focus on changes in the experience of current service users only in 1970 and 1975—those who knew what the services were like at the time. Moreover, this is the only way to find out whether there have been advances in features of provision which cannot be easily controlled centrally, nor monitored by the collection of routine statistics. We shall be looking here, then, at whether actually using the services was easier and pleasanter in 1975 than in 1970, and begin by continuing the examination of accessibility and considering GP as well as clinic use.

The most striking feature of a comparison of the accessibility of the services experienced by current users in the two years is how little it had changed. Distributions of reported journey times were very similar and periods spent in waiting rooms, and therefore of the total duration of visits, had altered little (Table 3.3). This was most apparent in the case of GPs, and hardly less so for clinics. There was, however, evidence of a small reduction in waiting times most, but not very, marked for clinics.

Despite this small apparent improvement, clinics, as was to be expected, remained less accessible than GPs in that both reported travelling and waiting times were longer in the former case.

Table 3.3 Accessibility—time required to use the services in 1970 and 1975—current users only

	GP		Family planning clinic	
	1970	1975	1970	1975
	%	%	%	%
Time taken to travel to:				
1/2 hour	74	75	60	53
1 hour	16	18	24	31
1 hour—	7	7	11	13
1 hour—	1	..	4	2
2 hours+	{ 1	0	{ 4	..
to wait to see doctor:				
1/2 hour	52	58	26	32
1 hour	21	19	26	27
1 hour—	17	14	26	25
1 hour—	7	6	20	13
2 hours+	{ 7	1	{ 20	1
to get there and back:				
1/2 hour	27	2	5	1
1 hour	40	23	22	28
1 hour—	26	28	48	44
2 hours+	4	5	26	20
How travelled				
Bus	15	15	23	23
Car	34	39	51	51
Foot	47	44	19	23
Other	3	1	7	3
Base: fecund women under 41 who were current users = 100%	346	437	223	358

There was, moreover, little indication that clinics were latterly more likely than before to be within easy walking distance of women's homes. In 1970, 19 per cent of current users walked to and from the clinic, compared with 23 per cent in 1975. This contrasts with over 40 per cent of GP users who walked to their doctors in both years.

As in 1970, most of the clinic users in 1975 believed the clinic to be open 1 or 2 days a week, whilst GP users most commonly said their doctor held surgeries 5 or 6 days a week. However, 26 per cent of the 1975 clinic users reported clinics being open more often than twice a week, compared with 18 per cent in 1970 (Table 3.4a).

All these differences between the two years, although in the desired direction, are small and could be due to sampling error, but a much greater change appeared in the known opening times of clinics and it seemed that morning sessions were provided more often in 1975 than in 1970: 40 per cent of the 1975 women reported morning availability, compared with only 21 per cent in 1970. There was no commensurate reduction in availability at other times of day (Table 3.4b).

Table 3.4 Availability of GPs and clinics in 1970 and 1975—information from current users only

	Clinics		GPs	
	1970	1975	1970	1975
Availability:	%	%	%	%
a. Number of days per week outlet was known to be available:				
1	34	31	1	..
2	36	34	2	0
3	6	12	2	1
4	6	4	5	5
5	5	4	21	38
6	1	6	61	52
Don't know	9	9	8	3
b. Times of day outlet known to be available:				
mornings	21	40	87	94
lunch times	NA	11	NA	7
afternoons	34	36	75	69
evenings	74	66	52	60
Base: ever-married fecund current users under 41 = 100%	223	358	346	437

There were, then, indications of slight improvements in the accessibility of clinics and of greater advances in their availability between 1970 and 1975, whilst GPs evidently remained as easily accessible and frequently available as before. Despite this evidence, users in 1975 were just as likely as their counterparts in 1970 to say that visits for contraceptive advice were difficult to arrange. Twenty-one per cent of clinic users said this in 1970 and 23 per cent in 1975, whilst 7 per cent of GP users did so in the earlier year and 10 per cent in the later one.

(c) **Attractiveness** In 1974 the DHSS indicated to Health Authorities that the standard of privacy at clinics should be satisfactory and that there should be adequate changing facilities.⁹ In the preceding two years the reports on the 1970 survey¹⁰ and on the complementary study of service providers¹¹ suggested in more detail ways in which the services could be made more attractive to actual and potential users.

As in the case of accessibility, there was evidence of little change in the way users actually experienced the services between the two years (Table 3.5a). The only exception here is that a smaller proportion of GP users in 1975 than in 1970 said their doctor failed to provide sympathetic advice (1975—29 per cent, 1970—38 per cent). Service use was no less likely to seem embarrassing in the later year and, although the proportion reporting inadequate privacy appears to have declined a little, this may well be due to a slight difference in question wording in the two surveys,¹² since there was no change in experience of the specific aspects of privacy covered in both years: for undressing, talking to the doctor, and for examinations and fittings (Table 3.5b).

Table 3.5 Attractiveness of services in 1970 and 1975—Information from current users only

Attractiveness:	Clinics		GPs	
	1970	1975	1970	1975
a Aspects of attractiveness:				
Informant agrees that use of service is—	%	%	%	%
embarrassing	14	13	8	10
not private enough	21	15	9	2
not the way to get sympathetic advice	20	23	38	29
b Aspects of privacy:				
Informant disagrees that there is sufficient privacy for—				
changing and undressing	17	14	12	8
talking to the doctor	7	10	4	7
examinations and fittings	7	7	5	4
<i>Base: ever-married fecund current users under 41 = 100%</i>				
	223	358	346	437

This record of the way in which known or recommended improvements in accessibility and availability and the general standards of attractiveness has impinged on service users is at first sight

discouraging. It should be recalled, however, that a considerably larger proportion and number of women were service users in 1975 than in 1970. The services had evidently succeeded in catering for the increased load without any deterioration in any aspect of provision, and with some improvements. In addition, the evidence that past users formed a smaller proportion of those who had ever tried the services in 1975 than in 1970 suggests that the services may latterly have been more successful in retaining clients.¹³

3.3 Remaining deficiencies in the services

In the report on the 1970 survey we looked for deficiencies in the services largely by comparing the views and experiences of current users of each service, those who had used it in the past and no longer used any ('past-users'), and those who had never used any service ('never users'). The general and unsurprising finding was that whilst past users were more likely than current users to report unsatisfactory experiences, never users were distinguished by their comparative ignorance of what the service was like, and these differences were most marked in the case of clinics. The same analysis of the reports of the women interviewed in 1975 revealed an almost identical pattern.

The method was originally used in the hope that it would provide clues to why some women discontinued use and others never tried. For various reasons the hope seems unwarranted and although tables showing differences between current, past and never users will be given here for comparative purposes, we shall concentrate on features which appear to be unsatisfactory however revealed, and whether or not they actually impede service use.

(a) **Knowledge of the services** It has already been said that never users of the services were more likely than other women to lack knowledge about concrete features of service use, such as whether they were free and the length of time they might have to spend in the waiting-room. For most features, ignorance was naturally only common about clinics, since the majority of women are familiar with the general conditions at their own doctor's surgery.

It can therefore rarely have been what the clinic service was actually like which deterred never users from trying them. Nevertheless, ignorance of any source of contraceptive advice is clearly an obstacle to its use but, as it happens, an increasingly rare one. In 1975 12 per cent of the never users knew of no source of advice, local or otherwise, compared with 24 per cent of the larger group of never users in 1970. Altogether, 78 per cent of

⁹DHSS—Health Service Circular (Interim Series) 32, Memorandum of Guidance—DHSS 1974.

¹⁰Bone M *op cit*.

¹¹Mitton R—Family Planning Clinics in 1970—*Family Planning*—July 1973. Cartwright A and Waite M—General Practitioners and Contraception in 1970–71—*Journal of the Royal College of General Practitioners*, Supplement No 2, Fol 22, 1972.

¹²Informants were asked whether they agreed or disagreed with the statement that family planning clinics/GPs were: 1970 'not private enough', 1975 'private enough'. (See Question 61 in Interview Schedule shown in Appendix I for question in full.)

¹³Conclusive evidence of improved service continuation rates could only be provided by individual histories of service use for both samples.

the 1975 never users knew of a local family planning outlet, and 56 per cent of the corresponding 1970 group. As mentioned earlier, it is not known to what extent such lack of knowledge as remains arises from the women's lack of interest, inadequate publicity, or the absence of local outlets.

(b) **Accessibility and availability** As in 1970, current clinic users were more likely than past users to report that journeys to the clinic, and periods spent in the waiting-room, each lasted less than 15 minutes. Almost a third of never users did not know how long such a journey would take, and two thirds had no idea how long they might have to wait to see the doctor once they arrived. In the case of GPs, there were in 1975, as in 1970, negligible differences between current, past and never users, and for all three groups the reported journey and waiting times were usually briefer than those recorded for clinics (Table 3.6).

Not only were the women's GPs more accessible than clinics, they were also, as was evident from the experience of current users, typically available throughout the week by contrast with the usual 1 or 2 days on which clinics were known to be open (Table 3.7a). A small proportion of women (6 per cent) knew their doctor held special sessions for providing contraceptive advice, and it may be that for some of this group their GP's family planning service was no more available than that of clinics. Nevertheless, the great majority of women evidently had more choice of when they went to their GP for advice than of when they visited a clinic. This applied not only to the day of week but also to the time of day each outlet was available. This has already been shown for current users, but it applied similarly to past users in so far as they knew when the outlet was open, which in the case of clinics they often did not. About a third of past clinic users and over 80 per cent of never users

did not know when the clinic was open¹⁴ (Table 3.7b.)

Clinics, according to current users, were most likely to be open in the evenings, and this was in fact the most popular time of day for family planning visits amongst every group of women (Table 3.8). Any local discordance between actual and preferred visiting times, moreover, is unlikely to have been a deterrent to most never users, since so many had no idea of when the clinic was open.

One point arising from Table 3.8 is that whilst evenings were the most popular time of day for visiting either outlet, especially clinics, many women preferred other times, which suggests that, where practicable, day-long availability is desirable or, alternatively, availability at different times on different days.

(c) **Attractiveness** Larger proportions of past than current users of each service said in 1975, as in 1970, that they had found their visits embarrassing, lacking in privacy, and that they had failed to get sympathetic advice. Never users, whilst more willing to venture opinions on these aspects of provision than on accessibility and availability, were, nevertheless, more likely than others to say they did not know whether privacy would be adequate, or advice sympathetic, but they more commonly expected embarrassment than had been experienced by those who had actually used the services (Table 3.9).

Of interest is an increase since 1970 in the proportion of never users who expected sympathetic advice on contraception from their own doctor (61 per cent compared with 48 per cent). A similar change in the actual experience of current GP users was noted earlier. How this improvement

¹⁴Percentages include those who knew of no clinic.

Table 3.6 Accessibility of family planning services 1975—current, past and never users' reports compared

	Clinics			GPs		
	Current users	Non-users		Current users	Non-users	
		Past users	Never users		Past users	Never users
Time taken to travel there:	%	%	%	%	%	%
½ hour	53	44	33	75	72	73
½ hour—	31	31	22	18	20	20
½ hour or more	15	20	12	7	8	7
Don't know	..	4	31	..	..	..
to wait to see doctor:						
½ hour	32	20	10	58	52	51
½ hour—	27	24	7	19	22	19
½ hour or more	39	44	15	22	24	27
Don't know	2	11	66	1	1	3
Base: fecund women under 41 = 100%	358	269	515	437	387	515

Table 3.7 Availability of family planning services 1975—current, past and never users' reports compared

	Clinics			GPs		
	Non-users			Non-users		
	Current users	Past users	Never users	Current users	Past users	Never users
a. Number of days per week outlet believed to be available:	%	%	%	%	%	%
1	31	22	5	..	..	..
2	34	23	3	0	0	1
3	12	8	1	1	1	2
4	4	1	..	5	5	4
5	4	9	2	38	37	35
6	6	4	1	52	54	53
Don't know	9	32	82	3	2	6
No answer	..	2	5	1	0	..
b. Times of day believed to be available:						
mornings	40	21	4	94	97	92
don't know if open mornings	9	32	82	3	2	6
lunch times	11	6	1	7	8	6
don't know if open lunch times	10	32	82	3	2	6
afternoons	35	24	5	69	68	66
don't know if open afternoons	9	32	82	3	2	6
evenings	66	46	7	60	63	58
don't know if open evenings	11	34	83	3	2	6
Base: fecund women under 41=100%	358	269	515	437	387	515

Table 3.8 Most convenient visiting times for family planning advice 1975—current, past and never users compared

	Clinics			GPs		
	Non-users			Non-users		
	Current users	Past users	Never users	Current users	Past users	Never users
Most convenient visiting times:	%	%	%	%	%	%
Mornings	29	29	23	14	39	37
Lunch times	5	5	3	4	4	5
Afternoons	20	21	18	15	18	19
Evenings	53	51	27	45	48	45
Other	1	1	..	2	2	1
Not known	1	4*	33*	2	2	7
Base: fecund women under 41=100%	358	269	515	437	387	515

*Includes those who did not know whereabouts of a clinic.

Note: Percentages total to more than 100 because some women gave more than one most convenient time of day.

Table 3.9 Attractiveness of family planning services 1975—views of current, past and never users compared

	Clinics			GPs		
	Non-users			Non-users		
	Current users	Past users	Never users	Current users	Past users	Never users
Service used is:	%	%	%	%	%	%
embarrassing:						
Agree	13	18	28	10	16	22
Disagree	87	82	67	88	83	70
Don't know	..	..	3	0	..	7
private enough:						
Agree	84	77	55	96	95	88
Disagree	15	22	22	2	4	4
Don't know	0	..	21	0	..	2
the way to get sympathetic advice:						
Agree	71	65	54	63	60	61
Disagree	23	30	19	29	32	22
Don't know	3	3	18	1	3	8
Base: fecund women under 41=100%*	358	269	515	437	387	515

*No answers are excluded from the table, and percentages therefore do not necessarily add to 100%.

has come about is a matter for speculation and it may in part be due to a growing belief by GPs and their patients that providing contraceptive advice is a proper function of the family doctor.

Although neither embarrassment nor lack of privacy was feared or experienced by large proportions of women, both aspects of provision are worth further examination, since the identification and elimination of such shortcomings may be simple at a local level.

(i) Embarrassment In 1970, when women were asked to explain their embarrassment, it appeared that two situational sources of embarrassment were: having to deal with a male doctor, which was said mainly of GPs, and dislike of an internal examination, mentioned usually in connection with clinics.

As in 1970, the great majority of women had a male GP in 1975 (89 per cent) and it is of interest to know whether this could have inhibited many never users from asking their own doctor for advice. In fact, 24 per cent of never users said they would prefer advice from a woman doctor, an almost identical proportion to that found in the larger corresponding group in 1970.

Very few women were so opposed to internal examination that they would have refused one if seeking contraceptive advice, although larger numbers would have avoided it if possible. Amongst never users, about 3 per cent said they would refuse internal examination at a clinic, and a similar proportion by their GPs. Fourteen per cent would not have refused but would have tried to avoid one at a clinic, and 10 per cent by GPs.

Women who had used clinics were not asked whether they had had an internal examination, but the fact that most current clinic users (92 per cent), but less than half the current GP users (43 per cent), had ever had to take off any clothes whilst visiting for contraceptive advice suggests that such examinations remain the rule at clinics but are much less common at GPs. Despite this persisting difference between outlets, it seems that examinations by GPs giving contraceptive advice were becoming more usual; in 1970 a quarter of current GP users had had an examination or fitting compared with 39 per cent in 1975.

(ii) Privacy Only current users were in a position to know whether adequate privacy was presently being provided by the service they used, and it was shown earlier that clinics did rather less well than GPs in this respect. The greater lack of privacy perceived at clinics applied not only to the total experience but to the specific activities of changing and undressing, talking to the doctor and being examined or fitted (see Table 3.5a and b.) In

1975, the questioning on privacy was extended to cover the process of reception and the waiting-room situation. It turned out that for both outlets these were the aspects most commonly seen as lacking adequate privacy, and ones, moreover, which most clearly distinguished clinics from GPs. Nineteen per cent of current GP users said there was insufficient privacy at reception, compared with 43 per cent of clinic users, whilst 20 per cent of GP users and 33 per cent of clinic users complained of inadequate privacy in the waiting-room.¹⁵

The situation at reception and in the waiting room may make women feel uncomfortable but it is unlikely to be as embarrassing as a lack of seclusion during or after undressing. In fact, most of the current users of each outlet who had undressed had done so alone in a room, cubicle or behind a screen. But 27 per cent of clinic users and 20 per cent of GP users had done so in the doctor's room with the doctor present. Evidently many of the women involved did not mind this, since far fewer than undressed in the doctor's room complained of the lack of privacy for undressing. Only very small proportions of women reported that they had undressed in rooms with other women present.

The vast majority of women who removed clothing at either outlet were given no dressing-gown to wear after doing so, but most of these either did not have to wait before seeing the doctor or did so in seclusion. However, 7 per cent of the partially-clad clinic users had waited in the waiting-room, but only one GP user.

3.4 Summary and Discussion

In each of the 5-year periods since 1960 there have been major innovations in contraceptive provision. In 1961 the pill first became generally available; in 1968 family planning services for all became national policy and the responsibility of the National Health Service rather than of voluntary bodies having more limited means; and in 1974-5 the services and supplies became free. The indications are that the initial upsurge in use of the services occurred at about the time the pill was introduced and that it has increased at a constant rate at least since 1967. Given this existing trend, it is difficult, if not impossible, to determine the effects of the most recent innovations, since it cannot be known whether the movement evidently triggered by the introduction of the pill would

¹⁵The question on privacy in general is outlined in the footnote on p 16 and is part of Question 61 on the Interview Schedule. Informants' views on the privacy of specific aspects of clinic/GPs use were elicited by asking whether or not they thought there was or would be enough privacy 'in the waiting room', 'for talking to the doctor without being overheard' etc. The full sequences of questions are 62-64 and 69-71 on the interview schedule reproduced as Appendix I.

have lost momentum but for the more recent changes. Moreover, in the second half of the fifteen-year period certain social and economic trends in this country and Western society as a whole could well have increased people's demand for effective contraception, even had no improvements in the services occurred. Lastly, free services were only introduced in 1974 and 1975 and any impact they have may occur after the 1975 survey.

In these circumstances, it is perhaps not surprising that we were unable to find conclusive evidence that the introduction of free services and growth in the number of clinics had produced an acceleration in the rate at which service use increased. This does not mean that the innovations had no effect, but that their impact was, up to 1975, at least less dramatic than might have been expected.

The reports of women actually using the services in 1970 and 1975 show that their experiences were very similar: each outlet, GPs and clinics, was more or less as easy or difficult, pleasant or discomforting to use in both years. Since the services were catering for more women in 1975 than in 1970, the evidence that there had been no perceived deterioration in conditions is perhaps itself remarkable. The few changes which had occurred over the period, moreover, were improvements:

slightly reduced waiting times at clinics, their availability at more times of day and probably on more days each week, as well as a commoner experience of sympathetically-provided advice from GPs.

Some deficiencies in provision evidently remained. Clinics were still less accessible or available than GPs and more time-consuming to use. To remove this disparity between outlets would be expensive and there is no evidence that it was an important reason for non-use.

There is also no reason to suppose that many women were deterred by such discomforting features of provision as a lack of privacy, although large numbers of users reported this at reception and in the waiting-room, particularly at clinics. On the other hand, it is likely that these sources of unease could often be removed by changes in procedure or organisation which involve no cost. The elimination of the internal examination, which some women strongly dislike, except when it is necessary (before IUD insertion and for the cap) or preferred by the client, might in fact reduce costs per client and save time.¹⁶

¹⁶This ignores the question of whether it is desirable to carry out a screening procedure for gynaecological disorders at the same time as contraceptive advice is provided.

4 Changes in contraceptive use 1970–1975

4.1 Introduction

Changes in contraceptive use between 1970 and 1975 are described in this chapter, together with the prevailing trends in 1975 implied by differences in the contraceptive behaviour of successive marriage cohorts. A fuller picture of contraceptive use at particular stages of marriage and over a period of nearly 25 years is given in Chapter 7.

Sterilisation, which is dealt with in Chapter 5, is not considered here.

4.2 Changes in contraceptive use

Between 1970 and 1975 use of the pill greatly increased whilst use of the condom declined. The pill is the method most commonly provided through the family planning services, and the services are currently its only authorised source (other than private doctors). Since use of the services had increased between 1970 and 1975, a corresponding increase in use of the pill was to be expected. In fact, the proportion of women at risk of unintended conception who were using the pill rose from 25 per cent to 42 per cent between the two years. Use of IUDs, similarly obtainable only through the services, had also increased, but only from 5 per cent to 9 per cent, and it therefore

remained the method of a small minority (Table 4.1).

During the same period, use of the less reliable non-appliance methods, withdrawal and the safe period,¹ had declined, but so also had that of the relatively effective barrier techniques, the condom and diaphragm. This means that overall, use of all the more effective methods has grown less than use of the pill. The use of more than one method in each year by some couples, however, may obscure the size of the increase in the more effective methods.

Table 4.1 appears to show a rise in non-use by women at risk from 7 per cent to 11 per cent. But this is due to a technical difference between the two years in the compilation of the figures, which means that those whose marriage had ended are shown as using no method in 1975, but as practising abstinence in 1970. The proportions who were either abstaining or using no method had not changed, and amongst the currently married at risk only 7 per cent were using no method in 1975.

¹A number of different procedures to enable women to identify the 'safe period' are in use. Very low failure rates are claimed for at least one of these—the 'Billings method' which is currently undergoing field trials sponsored by the WHO

Table 4.1 Changes in contraceptive use between 1970 and 1975—current use amongst ever-married women under 41 years

Current use of contraception:	All women under 41		Fecund women			
			Total		Those not pregnant nor trying to conceive	
	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%
Withdrawal	14	5	16	6	19	7
Pill	19	30	21	36	25	42
IUD	4	6	4	8	5	9
Diaphragm	4	2	5	2	6	3
Condom	28	18	31	22	36	25
Safe period	5	1	5	1	6	1
Abstinence [§]	3	1	3	1	4	1
Other methods*	NA	3	NA	4	NA	4
None [§]	29†	37†	21	23	7	11
Base: ever-married women under 41 = 100%‡						
	2,520	2,344	2,241	1,913	1,895	1,655

*For 1975 'Other methods' includes combinations and alternations of methods also listed separately. For 1970, 'Other methods' would have included douching (negligible) and spermicides which in most cases were used together with another method. 5% of those at risk were using spermicides or douching in 1970.

†Includes women who were, or whose husbands were, sterile.

‡Percentages add to more than 100 because some people used more than one method.

§In 1975 women no longer married are included in 'None'; in 1970 they were included in 'Abstinence'.

Because the interest here is in current use of contraception, the discussion which follows will be confined to the experience of the women at risk—those who were fecund and neither pregnant nor trying to conceive.

4.3 Current use of contraception by year of marriage

As in 1970, use of the pill in 1975 increased with year of marriage, so that 29 per cent of those married between 1956 and 1960 were users, but 60 per cent of the women married after 1970. By contrast, use of the condom appeared to decline with each successive generation, and particularly sharply for the most recently married.

It remains to be seen whether condom use will continue so low for the couples married during the 1971–75 period, or whether, with time, more of them will find it a suitable method so that users continue to form something over a quarter of couples, as suggested by the behaviour of cohorts married between 1956 and 1970.

In both cases the changes operated within marriage cohorts over time and between cohorts. In other words, it appeared that successive marriage cohorts were making more use of the pill and less of the condom than their predecessors but also that between 1970 and 1975 more women in each cohort, except for the 1951–55 marriages, had adopted the pill and abandoned the condom. The inter- and intra-cohort reductions in the use of withdrawal were similar to those for the condom, except that it had been largely rejected even by the earliest cohort—those married in 1951–55.

As in the case of service use, changes within generations over the 5-year period are best shown by the behaviour of the population of women sampled in 1970, at that time and five years later; in practice, women who were under 41 in 1970 and those who were under 45 by 1975.² The current contraceptive practice of all under 45s in 1975 is shown in Table 4.2(a) and compared, in the case of

²As noted in Chapter 2, women under 41 in 1970 were aged up to and including 45 in 1975, but the age grouping adopted in 1975 for other purposes means that those aged 45 years in 1975 are excluded from the comparison.

Table 4.2 (a) Current use of contraception 1975 by year of marriage*—women under 45 years—at risk

1975	All years	Year of marriage				
		1951–55	1956–60	1961–65	1966–70	1971–75
	%	%	%	%	%	%
Method currently used:						
Withdrawal	8	15	10	8	5	6
Pill	37	16	25	33	44	60
IUD	8	4	8	10	11	5
Cap	3	3	4	3	4	2
Condom	28	37	32	29	26	17
Safe period	1	2	1	2	1	1
Abstinence	1	1	1	2	1	1
Other	5	7	4	5	4	2
None	13	21	18	11	9	8
Base: ever-married women under 45 at risk = 100%	1,956	221	396	411	489	404

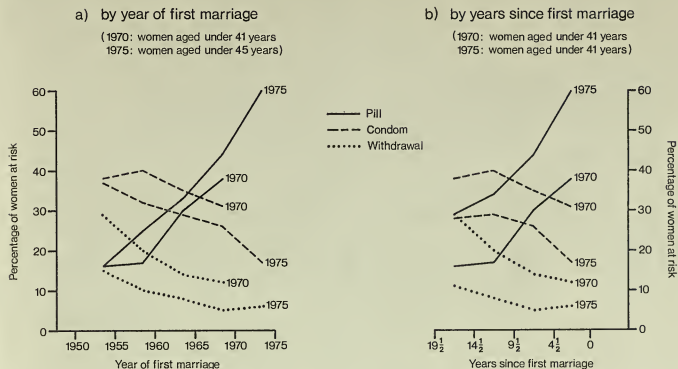
Table 4.2 (b) Current use of contraception 1975 by year of first marriage*—women under 41 years—at risk

1975	All years of marriage	Year of first marriage				
		1951–55	1956–60	1961–65	1966–70	1971–75
	%	%	%	%	%	%
Method currently used:						
Withdrawal	7	9	11	8	5	6
Pill	42	26	29	34	44	60
IUD	9	6	8	10	11	5
Cap	3	2	3	3	4	2
Condom	25	36	28	29	26	17
Safe period	1	4	1	2	1	1
Abstinence	1	0	1	2	1	1
Other	4	8	4	5	4	2
None	11	17	17	11	9	8
Base: ever-married women under 41 at risk = 100%	1,655	53	309	400	485	404

Note: Percentages may add to more than 100 because some couples used more than one method.

*Because of the upper age limit there is an age-at-marriage bias in the cohorts; eg women who married in 1951–55 must have been under 20 when they married in order to be under 41 at the time of the 1975 survey, but a woman who married in say 1971 could have been any age under 37 at her marriage.

Figure 4.1 Current contraceptive use – examples of the pill, condom and withdrawal



specific methods, with that of the under 41s in 1970 in Figure 4.1(a). It can be seen from the Figure that within each marriage cohort use of the pill had increased somewhat over the five years, whilst use of the condom and withdrawal had declined.

Differences between cohorts in 1975, on the other hand, are demonstrated by figures for the women under 41 in 1975 (Table 4.2(b)) and compared with the 1970 data on the basis of the period between first marriage and interview (Fig. 4.1(b)).

This shows that in 1975, as in 1970, the more recent the first marriage the more common was the

use of the pill. It also demonstrates that for every marriage duration use of the pill was greater and use of the sheath and withdrawal less in 1975 than in 1970.

Taken together, the information in figures 4.1(a) and (b) suggest that the changes between 1970 and 1975 form part of a continuing trend.

Non-use of contraception by those currently married and at risk, according to year of marriage, is shown in Tables 4.3(a) and (b). It can be seen that this is greatest amongst those married before 1961, the women who presumably were least likely to want further children. This circumstance

Table 4.3 Current non-use of contraception by currently married women at risk 1975 according to year of marriage†

1975	All years	Year of first marriage				
		1951-55	1956-60	1961-65	1966-70	1971-75
	%	%	%	%	%	%
(a) Women under 45: Uses no method	8	14	10	5	7	6
Base: currently married women < 45 at risk = 100%	1,864	206	362	386	477	400
(b) Women under 41: Uses no method	7	12	10	4	7	6
Base: currently married women < 41 at risk = 100%	1,588*	51	285	375	473	400

*Total includes 4 women either married before 1951 or whose date of marriage is unknown.

†See note to Table 4.2 (a) and (b).

Table 4.4 Current use of contraception by social class—1970 and 1975, married women under 41 at risk

	All classes Social class				
		Non-manual	Manual		Total
			III	IV & V	
Currently used:	%	%	%	%	%
(a) 1975—Withdrawal	7	4	8	13	9
Pill	42	42	43	39	42
IUD	9	9	9	7	8
Cap	3	5	2	1	1
Condom	25	28	24	24	24
Safe period	1	1	1	1	1
Abstinence	1	2	1	1	1
Other	4	4	4	4	4
None*	11	9	12	14	13
<i>Base: married women under 41 at risk =100%</i>					
	1,655	672	707	276	983
(b) 1970—Withdrawal	19	12	23	22	22
Pill	25	28	24	21	23
IUD	5	6	5	4	5
Cap	6	10	3	4	3
Condom	36	38	35	36	35
Safe period	6	8	6	3	5
Abstinence	4	3	3	7	4
Other	NA	NA	NA	NA	NA
None*	7	2	7	10	8
<i>Base: married women under 41 at risk =100%</i>					
	1,895	675	840	345	1,185

*1970 non-users exclude those whose most recent marriage has ended.

1975 non-users include those whose most recent marriage has ended.

will be examined again in relation to age in Chapter 6.

4.4 Current use of contraception by social class

In 1970 the main difference between the social classes was that the manual group was more likely than the non-manual to report use of withdrawal, and rather less likely to mention the pill or barrier methods. The difference in pill use was greatest for the most recently married, so that it appeared that the wives of manual workers were inclined to adopt it, if at all, later in marriage than other women.

Although differences in contraceptive practice between the classes were still just perceptible in 1975, they had diminished and, in particular, use of the pill was as common in the manual as in the non-manual group (Tables 4.4(a) and (b)). Moreover, the similarity in pill use applied to women still in the early years of marriage—the 1971–75 cohort (Table 4.5).

On the other hand, slightly larger proportions of the manual couples than others represented were still using withdrawal: the proportion was greatest for those in classes IV or V and applied to every marriage cohort.

The figures for contraceptive use are based on

women at risk of unintended conception and therefore conceal the fact that amongst the recently married a higher proportion of the non-manual than manual group were at risk: 80 per cent compared with 71 per cent. This was mainly because wives of manual workers were rather more likely than other women at the same stage of marriage to be pregnant or trying to get pregnant.

4.5 The methods provided through the services

It was stated at the beginning of this chapter that the pill was the method most commonly provided through the services. In fact, 77 per cent of current service users were taking the pill. The proportions using each method, however, varied according to the outlet used, and a few women using no service according to the survey definition nevertheless said they were employing service specific methods.

Ninety per cent of GP users were receiving the pill, compared with 65 per cent of clinic users. On the other hand, only 2 per cent of GP users had an IUD, but 22 per cent of clinic users. Diaphragm use was low amongst clients of both services, but greater amongst clinic than amongst GP users (Table 4.6).

Although condoms can be obtained free on consultation through the services, it can be seen

Table 4.5 Current use of contraception by social class and year of marriage

1975	Year of first marriage and social class											
	1956-60			1961-65			1966-70			1971-75		
	Non-manual %	IV & V %	All manual %	Non-manual %	IV & V %	All manual %	Non-manual %	IV & V %	All manual %	Non-manual %	IV & V %	All manual %
Method currently used:												
Withdrawal	9	13	12	5	15	11	2	10	7	4	11	7
Pill	30	30	29	33	26	34	42	43	46	60	60	59
IUD	12	3	6	12	9	9	9	11	12	5	3	5
Cap	5	2	2	4	2	2	7	1	1	2	0	1
Condom	31	30	27	30	18	28	29	26	23	20	17	15
Safe period	0	0	1	3	2	2	2	0	0	1	0	1
Abstinence	1	2	1	3	4	2	2	0	0	1	0	1
Other	6	5	3	5	0	5	3	4	5	2	4	3
None*	13	18	20	10	24	11	7	10	10	5	8	10
Base: ever-married women <41 years at risk = 100%	101	60	208	186	54	214	204	72	281	166	70	238

*Includes those whose most recent marriage has ended.

that it was the method of only a tiny proportion of the couples represented by women who were current service users.

Comparable information on the contraceptive practice of different service users is not available from the 1970 survey so that it is not possible to say how if at all the situation had changed.

Six per cent of past service users in 1975 said they were taking the pill, and 11 per cent were using an IUD. According to our criteria, a woman was classified as a past user if she had used one of the services in the past, and either had not visited the outlet within the 12 months preceding interview or had visited in that period but indicated that she did not mean to return.

About half of the small number (23) of past users who were on the pill had visited an outlet within the last year and may have been finishing the supply they last received, but the other half had not visited for a year or more. Four per cent of never users said they were taking the pill.

Amongst the 42 past users still wearing an IUD, most (39) had not visited an outlet during the past year, although the majority of these had done so within the previous 2 years. The recommended period between visits for check-ups on IUDs is 12 months,³ and it may be that the 26 women who had last visited an outlet between 1 and 2 years before interview had an imminent appointment. It is nevertheless worth comment that over a quarter (27 per cent) of current IUD users under 41 had not visited the services for a year or more, and that 10 per cent said they had not visited for at least 2 years.

4.6 Summary

The increase in service use between 1970 and 1975 had been accompanied by a corresponding growth in the use of the principal service specific method—the pill—and, to a lesser extent, of the IUD. On the other hand, use of the diaphragm, the historical service specific method, had declined.

As a corollary, use of the least effective methods, withdrawal and the safe period, had declined, but so also had use of the relatively effective condom.

The small difference visible in 1970 between the social classes in use of the pill had disappeared by 1975, but use of withdrawal remained rather more prevalent in the manual than in the non-manual group.

³The *Handbook of Contraceptive Practice* (DHSS 1974) suggests that patients wearing IUDs should be seen at approximately 6 weeks, 6 months and thereafter annually if all remains well.

Table 4.6 Current use of contraception according to service outlet used and user status—ever-married women under 41 years at risk

1975	User status and outlet used						
	Current users					Past users	Never users
	GP	Clinic	Other doctor	Other	Total		
	%	%	%	n	%	%	%
Method currently used:							
Withdrawal	..	1	0	0	..	11	17
Pill	90	65	43	9	77	6	4
IUD	2	22	40	0	12	11	0
Diaphragm	1	8	3	0	4	3	..
Condom	3	2	3	2	3	47	50
Safe period	0	0	0	0	0	2	3
Abstinence	..	0	3	0	..	3	2
Other	..	1	3	1	1	6	8
None*	2	3	6	0	3	17	22
Base: ever-married women under 41 at risk† = 100%	437	354	35	11	837	381	434

*Includes those not currently married.

†Some columns add to more than 100 because some couples used more than one method.

Note: Figures in italics are actual numbers where the total is too small for percentages to be meaningful.

5 Sterility, sterilisation and those 'at risk'

5.1 Introduction

The subject of this chapter serves as a link between the topic of changes from 1970 to 1975 amongst women under 41, and that of the situation in the latter year of all ever-married women under 56. It is concerned both with how changes have come about in the extent of sterility and risk of unintended conception, and with the way in which both varied with age in 1975. The first is of interest because it shows how the potential clientele of the services is changing, whilst the second indicates the limits of possible demand for the services in 1975 and therefore provides the context for considering service and contraceptive use by the broader age band of women in the following chapter.

5.2 The extent of sterility and risk of unintended conception

Nearly 70 per cent of the ever-married women aged 16-55 believed themselves and, where applicable, their husbands to be capable of further conception, and 62 per cent were fecund in this sense, and also neither pregnant nor trying to conceive—that is, 'at risk'. If the women who were no longer married are removed from the 'at risk' group, on the supposition that they were sexually less active than the currently married, then 58 per cent of all the women were 'at risk'. Since we did not ask about sexual activity, we cannot verify this assumption and in the following tables and comment all ever-married women in the age range will be covered, but the way in which the proportions of women no longer married increased from the late 30s upwards is shown in Table 5.1.

As might be expected, the percentages of women who believed themselves or their husbands to be infecund increased with advancing age, and most precipitously after the age of 44 (Fig. 5.1 and

Figure 5.1 Proportions of women who were sterile (or whose husbands were sterile) or at risk according to age at interview – ever-married women aged 16-55

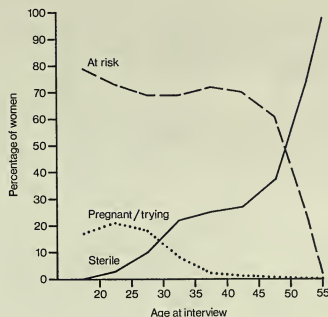


Table 5.2). The age-related pattern of women 'at risk', however, did not perfectly reflect the rising tide of sterility and this was because of a decline after the early 20s in the proportion who were pregnant or trying to conceive: thus, just over 20 per cent of those aged 20-24 had excluded themselves from the 'at risk' group in this way, but only 2 per cent of the 40-44 year olds. In fact, the proportion 'at risk' appears to have been slightly higher amongst those aged 35-44 than in the 30-34 year old group, just because at this point the decline in reproductive behaviour was not complemented by an equivalent rise in sterility.

Table 5.1 Percentages of women separated, divorced or widowed according to age

Marital status:	All ages	Age at interview								
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55
	%	%	%	%	%	%	%	%	%	%
Currently married	93	95	96	95	95	93	92	91	89	84
Separated/divorced/widowed	7	5	4	5	5	7	8	9	11	16
Base: ever-married women 16-55 = 100%										
	3,898	42	372	661	601	558	531	514	568	51

Table 5.2 Percentages of ever-married women who were sterile (or whose husbands were sterile), fecund and at risk in 1975, according to age at interview

Risk group	All ages		Age at interview								
			<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55
	%	%	%	%	%	%	%	%	%	%	%
Sterile	30	0	3	10	22	25	27	37	74	98	
Fecund	69	95	94	87	76	74	72	61	24	2	
and pregnant/trying and not pregnant nor trying to conceive = 'at risk'	7	17	21	18	8	2	1	..	0	0	
Not known	62	79	73	69	69	72	70	61	24	2	
	2	5	3	3	1	1	2	2	1	0	
Base: ever-married women under 56 = 100%											
	3,898	42	372	661	601	558	531	514	568	51	

Table 5.3 Percentages of ever-married women who were sterile (or whose husbands were sterile), fecund and at risk, 1970 and 1975, those under 41 years only

Risk group	1970		1975	
	%	%	%	%
Sterile	11	17		
Fecund	89	82		
and pregnant/trying to conceive	14	11		
and not pregnant nor trying to conceive	75	71		
Not known	—	2		
Base: ever-married women under 41 = 100%				
	2,520	2,344		

The proportion of women at risk was evidently changing over time and this is shown when the women under 41 in 1975 are compared with the corresponding 1970 group (Table 5.3). The proportion of women who were or whose husbands were infecund had increased from 11 per cent to 17 per cent over the 5 years, but the effect of this on the extent of the 'at risk' group had been muted by a small decline in the percentage who were pregnant or trying to conceive. For this reason, those 'at risk' had been reduced only from 75 per cent to 71 per cent of the women under 41. Each of these differences is quite small and could be due to sampling and other errors. They do, nevertheless,

conform to expectations¹ and in the case of rising sterility are corroborated by the later evidence about its sources.

The apparent changes incidentally illustrate the way in which the size of the 'at risk' group depends not only on the extent of sterility, but also on the actual and intended fertility rate (and, of course, on the number of married women in the age group).

5.3 Sources of infecundity

The apparently growing prevalence of sterility amongst women under 41, or their husbands, indicates well enough that the condition is not only due to natural causes, and in fact over half of the sterile couples represented by the women under 56 were in this state because of an operation, and the majority of these operations (about two-thirds) had been intended to prevent conception—sterilisation.

For the age groups under 35, sterilisation was the major source of infecundity, whilst for older women other sources, including other operations

¹ i.e. fertility has declined in England and Wales over recent years—see *Population Trends* 6, Winter 1976, London HMSO, pp 1-2

Table 5.4 Sources of infecundity in women or their husbands according to women's ages at interview—ever-married women under 56

Stage and source of infecundity*	All ages		Age at interview								
			<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55
	%	%	%	%	%	%	%	%	%	%	%
Fecund	70	100	97	90	78	75	73	63	26	2	
Infecund:											
sterilisation	11	0	3	9	18	18	13	9	4	2	
other operation	6	0	0	1	1	3	8	11	15	16	
post-menopausal	10	0	0	0	0	0	2	13	52	74	
other causes	3	0	0	1	3	4	4	4	4	6	
Total infecund	30	0	3	10	22	25	27	37	74	98	
Base: ever-married women under 56 = 100%											
	3,898	42	372	661	601	558	531	514	568	51	

*Includes 2% whose state is not known—see Table 5.2 for distribution.

resulting in sterility, were dominant, but it was only for those in their 50s that natural causes, of which the menopause was the most important, became the principal source (Table 5.4). Sterilisation and the menopause will be further examined in the two following sections.

There remains a very small group of couples, represented by 3 per cent of the women, who were infecund—unable to conceive—for other reasons.

A difficulty occurs in this case because it seems probable that most of the naturally infecund learn of their inability to conceive from experience and only classify themselves in this way after they have been trying unsuccessfully to get pregnant for some time and perhaps have been told by a physician that conception is impossible. During a period when contraception is widely practised, even in the early years of marriage (see Chapter 4), the time required to discover infecundity may be considerable. This may partly account for the increase in the proportions shown as sterile for 'other reasons' between the 20s and 30s (see Table 5.4).

In addition to the 3 per cent of women representing couples sterile for 'other reasons', another 3 per cent reported difficulties in conceiving but were uncertain that conception was impossible, often because they understood this to be a physician's view. These women were excluded from the sterile category, but if they were to be added to the 'sterile for other reasons' group this would then include 6 per cent of the women. If only those aged 35–39 are considered, on the grounds that they have had the time to discover any difficulties in conception, but before the menopause supervenes, then the proportion affected is 4 per cent. It will become evident in the next chapter that this figure is almost certainly an underestimate.

5.4 Sterilisation and other operations resulting in sterility

(a) The proportion of women who, or whose husbands, had been sterilised. As expected, sterilisation had become more common between 1970 and 1975 and was evidently continuing to increase. In 1970, 6 per cent of the couples represented by the interviewed women (then aged under 41) had had operations resulting in sterility, and this included 4 per cent who had been sterilised—that is, had had an operation to prevent conception. In 1975, 14 per cent of the corresponding group were sterile as a result of an operation, including 13 per cent who had been sterilised. But the true dimensions of the change which has been occurring are scarcely suggested by this comparison.

Differences between the proportions of each age

group who had been sterilised indicate that the impact of recent practice had been mainly on women under 40, and this is exemplified by the 30 to 34 year olds, of whom 18 per cent had been sterilised. Even if no further sterilisations occur amongst the couples represented by these women, by the time they are aged 45–49, 18 per cent will still be sterilised, compared with only 9 per cent of those aged 45–49 when interviewed in 1975.

(b) Sterilisation rates To gain a clearer picture of the way sterilisations have been increasing it is useful to look at the sterilisation rates experienced by the sampled women over their lives before being interviewed; for practical purposes, since they became 20 years old.

(i) The method of calculating sterilisation rates The rates discussed and shown in Tables 5.5 and 5.8 are sterilisations as percentages of women in each age group who had the chance of being sterilised from the age of 20. They differ from straightforward percentages of women at the age of 20 in that the base number changes as women lose the chance of being sterilised (i.e. because they had another operation resulting in sterility) and, more importantly, as women are lost to observation (i.e. because they are interviewed before they reach the age of interest).

The rates of all operations resulting in sterility in Table 5.6 are calculated in the same way but in this case the only losses are to observation.

Losses to observation (by being interviewed before reaching the age of interest) of course occur in the particular age groups the women belonged to at the time of the survey.

The rates shown in brackets are therefore estimates because they refer to an age which no woman in the age group had quite reached at the time of interview. For example the cumulative sterilisation rate at age 35 for the women aged 30–34 at interview is that which the group will probably have experienced by age 35 when every woman in the group has reached her 35th birthday. It is based on the experience of the whole group up to the 30th birthday, and thereafter on the experience of each woman up to the age she had achieved at interview. Thus a woman aged 32 at interview contributes to the rate by her experience of being sterilised or remaining unsterilised and at risk until she was 30, during the time she was 30 and 31 and for some of the time she was 32. A woman of 34, on the other hand, will have contributed by her experience whilst she was 20 to 33 and for part of the time she was 34. The estimated rates will be wrong only if the unsterilised women in the age group who had not reached the eve of their 35th birthday at interview behave differently from their forerunners still in the age group, during the

Table 5.5 Sterilisation—Cumulative couple sterilisation rate per 100 ever-married women at risk by specified ages, according to age at interview

	Women's age at interview						
	20-24	25-29	30-34	35-39	40-44	45-49	50-54
	%	%	%	%	%	%	%
Women's age to which rate refers:							
25	(8.5)*	2.7	1.2	0.4	0.0	0.0	0.4
30		(13.0)*	9.5	2.6	1.4	0.2	0.7
35			(28.1)*	11.1	3.4	0.8	1.2
40				(25.9)*	11.1	3.6	1.6

*Standard errors for bracketed figures are: 8.5 Standard error = 1.2

13.0 " " = 1.7

28.1 " " = 2.2

25.9 " " = 2.2

Note: The few women who were sterile for 'other reasons' were excluded from the calculations. For the calculation of sterilisation rates, women who experienced other operations resulting in sterility were removed from the group still exposed to risk during the year of age in which the other operation occurred. For the calculation of both sterilisation and 'all-operation' rates, women who were interviewed before reaching the age of interest were also removed from the group exposed to risk during the year of age in which interview occurred.

Table 5.6 All operations resulting in sterility—Cumulative couple all-operation rate per 100 women at risk by specified ages, according to age at interview

	Women's age at interview						
	20-24	25-29	30-34	35-39	40-44	45-49	50-54
	%	%	%	%	%	%	%
Women's age to which rate refers:							
25	(8.5)*	2.8	1.2	0.4	0.0	0.0	0.2
30		(16.4)*	9.6	2.9	1.4	0.6	1.2
35			(30.9)*	12.5	5.1	1.9	2.3
40				(28.9)*	16.0	6.1	4.4

*Standard errors for 8.5 = 1.2

16.4 = 1.7

30.9 = 2.2

28.9 = 2.3

Note: The few women who were sterile for 'other reasons' were excluded from the calculations. For the calculation of sterilisation rates, women who experienced other operations resulting in sterility were removed from the group still exposed to risk during the year of age in which the other operation occurred. For the calculation of both sterilisation and 'all-operation' rates, women who were interviewed before reaching the age of interest were also removed from the group exposed to risk during the year of age in which interview occurred.

interval remaining between interview and their 35th birthdays.

(ii) **The trend in sterilisation rates** The way in which sterilisation rates (of the women or their husbands) have been changing is shown in Table 5.5. The rates experienced by women who were in different age groups in 1975 during successive 5 year periods of their lives indicate that a substantial increase has been occurring in recent years. For example, 11 per cent of the women aged 35-39 at interview or their husbands had been sterilised by the time the women were 35; by contrast only 1 per cent of the women who were 45-49 at interview had been sterilised by the age of 35.

Most striking are the estimated current rates, which show, for example, that over a quarter (28 per cent) of couples represented by the women aged 30-34 at interview will probably have been sterilised by the time the women reach their 35th birthday.

The reported dates of sterilisations suggest that they began to assume importance in 1967.

A possible if unlikely explanation of the apparent increase in sterilisation is that it is at least partly due to a change in the ostensible purpose of operations resulting in sterility. It could be that the incidence of such operations had not so greatly changed, but that the women who experienced them recently were more likely than others to say they were to prevent pregnancy. This possibility is not refuted by Table 5.4, showing the proportions of each age group who had had such operations, since the total percentages, affected by sterilisation or other operation, in each 5-year age group above 29 years are quite similar. However, the comparison of figures for 1970 and 1975 in Table 5.3 suggests this is unlikely, and Table 5.6 shows clearly that the rates for all operations resulting in sterility at specified ages under 40 had recently increased. For example, over 12 per cent of couples represented by women aged 35-39 at interview had had such

an operation by the time the woman was 35, but only 2 per cent of those represented by women aged 45-49. The apparent increase in sterilisation operations is therefore authentic and not due to a change in the reported purpose of operations resulting in sterility.

Because the majority of such operations have been sterilisations, the estimated current rates for all operations are also surprisingly high; for instance, at prevailing rates nearly a third (31 per cent) of the couples including a wife in the 30-34 year age groups are likely to have had an operation resulting in sterility by the time the women reach their 35th birthdays.

Over half the reported sterilisations had been of the women rather than of their husbands, but this, too, appeared to be changing and, amongst those under 30, there is a suggestion in Table 5.7 that it was the husband rather than the wife, if either, who had most commonly been sterilised. The reported dates of operation indicate that vasc-

tomies became the predominant form of sterilisation after 1970.²

The trends are again best illustrated by the sterilisation rates which prevailed amongst women of different ages at successive periods of their lives, but in this case for the women on the one hand and for their husbands on the other. It appears from Tables 5.8(a) and (b) that for couples represented by women under 30, vasectomies are becoming about twice as common as female sterilisation. For example, about 5 per cent of the 25-29 year old women whose husbands do not have vasectomies will probably be sterilised by the time they are 30; but some 10 per cent of husbands whose wives remain fecund will by then probably have had vasectomies. For couples represented by women aged 30 or more, the chances of each partner being sterilised have recently been about

²In 1972 the grounds on which vasectomy could be carried out under the NHS were extended to include family planning as well as health reasons.

Table 5.7 Percentages of women who had been sterilised and whose husbands had been sterilised, according to age of women at interview

State and member of couple sterilised	All ages	Age at interview								
		<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55
		%	%	%	%	%	%	%	%	%
Not sterilised	89	100	97	91	82	82	87	91	96	98
Sterilised:										
woman	6	0	1	4	9	10	7	7	3	2
husband	5	0	2	5	9	8	7	2	1	0
Total	11	0	3	9	18	18	13	9	4	2
<i>Base: ever-married women under 56 = 100%</i>										
	3,898	42	372	661	601	558	531	514	568	51

Table 5.8 Cumulative couple sterilisation rates per 100 women by specified ages according to age at interview

Woman's age to which rate refers	Women's ages at interview				
	20-24	25-29	30-34	35-39	40-44
(a) Sterilisation of women					
25	(2.6)*	1.2	1.0	0.4	0.0
30		(5.4)*	4.8	2.2	1.4
35			(16.5)*	7.2	3.4
40				(13.1)*	6.6
(b) Sterilisation of husband					
25	(5.8)*	1.8	0.2	0.0	0.0
30		(10.5)*	5.2	0.4	0.0
35			(14.6)*	4.7	0.2
40				(15.7)*	5.7

*Standard errors for
 2.6=0.5 5.8=1.0
 5.4=1.3 10.5=1.4
 16.5=1.8 14.6=1.7
 13.1=1.8 15.7=1.9

Note: The few couples who were sterile for 'other reasons' were excluded from the calculations. For the calculation of woman-sterilization rates, women whose husbands were sterilised were removed from the group at risk during the year of age in which this occurred. Similarly, for the calculation of husband-sterilisation rates, women who themselves were sterilised were removed from the group at risk during the year in which this occurred. In both cases, women who were interviewed before reaching the age of interest were removed from the group at risk during the year of age in which the interview took place.

equal, but were earlier greater for the women than for their husbands.

5.5 The menopause

We defined women as post-menopausal if their last menstrual period (LMP) had occurred one year or more before interview, and as menopausal if the time between interview and LMP was less than one year but 3 months or more. This follows the procedure of Mckinlay and others.³

In the present survey, only the women who said they were incapable of having further children because they thought they had reached or passed the menopause were asked whether their last period had occurred longer ago than specified intervals before interview.

The proportions of women not otherwise sterile who were menopausal and post-menopausal, according to these definitions, are shown in Table 5.9, and it can be seen that there is a continuous steep increase from about the age of 47 in the proportion who were post-menopausal and that the great majority of those aged 54 or more were in this state.

The percentages who were post-menopausal at each age within the range 45–54 years are very similar to those found in 1965 by Mckinlay et al in a sample drawn from general practitioners' lists in and around London. The percentages classified as menopausal in the present enquiry are, however, strikingly smaller than in the London study, and this may be because of the initial screening question we used before going on to ask for the time elapsed since LMP—that is, it may be that women are reluctant to suppose they have ex-

perienced the menopause until about a year after LMP.

The median age at menopause—the age by which half the women who reach that age will have experienced their last period—was estimated to be 49 years 9 months.⁴ This is almost exactly the same as can be calculated from the findings of the London investigation of 1965.⁵ The similarity occurs despite subsequent changes in contraceptive behaviour which might have been expected to alter the age at menopause.

Firstly a higher proportion of women in the 1975 than in the earlier investigation had had an operation resulting in sterility (nearly 20 per cent compared with 11 per cent of those aged 45–55). It is possible that the distribution of age at menopause for these women had they not had such operations would have been different from that of the women who actually had no such operation.⁶ Secondly, use of the pill has increased since 1965. The effects of hormonal contraceptives around the age of menopause are not well documented, but it is very possible that their use masks the onset of the menopause by producing withdrawal bleeding which mimics the occurrence of regular menses. If this happens the effect should be to raise the apparent median age at menopause: that is, the median age found in 1975 should be higher than that found in 1965. However, only 9 per cent of the 45–49 year old women in the present survey were using the pill (see Chapter 6).

⁴A note on the method of calculating the median age is given at the end of the chapter.

⁵There appears to be an error of one year in the figure calculated by Mckinlay et al *op cit*—i.e. they give a median of 50.78 years, but recalculation, using their figures, gives a figure of 49.78.

⁶Monthly periods continue after most sterilisations (including female sterilisations) but the women involved were omitted from the calculations.

³S Mckinlay, M Jeffreys, B Thompson. An Investigation of the Age at menopause; *J. Biosoc. Sci.* (1972) 4, pp 161–173.

Table 5.9 Menopausal status by age at interview

Age (in years)		Pre-menopausal	Menopausal	Post-menopausal	No. of women 'at risk'* = 100%
40	%	97	1	1	No.
41	%	98	1	1	75
42	%	98	2	0	81
43	%	97	0	3	80
44	%	93	0	7	75
45	%	91	0	9	87
46	%	93	3	4	87
47	%	84	1	15	70
48	%	76	3	21	73
49	%	57	6	37	95
50	%	55	4	41	63
51	%	37	6	57	104
52	%	23	7	69	79
53	%	19	4	78	94
54	%	6	0	94	80
55	%	3	0	97	84
					39

*'At risk' here means at risk of being menopausal or post-menopausal and excludes those who were otherwise sterile.

5.6 Summary

From the age of 45 upwards the numbers of fecund women are progressively and heavily depleted by the occurrence of the menopause, but it is not until after the age of 49 that most have experienced the event. This is considerably higher than the conventionally used limit to the child-bearing years of 44, although sub-fecundity may increase some years before final menses occurs.

The growing prevalence of artificially induced sterility over the last few years, however, is likely to reduce the significance of the menopause as the termination of fecundity. The trend current in 1975 implied that almost a third of otherwise fecund couples represented by women aged 30-34 would have had an operation resulting in sterility by the time they were 35, and there is no reason to suppose that the younger couples were about to behave differently. Indeed, it is probable that about a sixth of the couples including a wife aged 25-29 at interview will already have become sterile for the same reason by the time the wives are 30.

Even if the proportion of women who are pregnant or trying to conceive were to continue to decline as it has, it seems probable that on recent trends the effect of this in increasing the size of the 'at risk' group—those who require effective contraception—will be overwhelmed by the inroads of sterility. That is, it is to be expected that the size of the potential service clientele as a proportion of married women will decrease.

There are three reasons why this may not result in a decline in effective demand. First, effective demand was still well under half of potential demand in 1975 (see Chapter 6) and evidently still growing. Second, recent sterilisations were most commonly of the husband. As nothing is known about the extent of extra-marital sexual activity, and some of the wives will divorce and remarry it cannot be assumed that none of the wives of sterilised husbands will want to use the services. Lastly, because the median age of sterilised couples has

evidently declined and their numbers increased, it may be that the demand for de-sterilisation will grow.⁷ If this occurs, its effect on the use of contraceptive services cannot be predicted from material in the present survey.

Note on estimation of median age at menopause

The median age, based on the proportions at each age whose LMP had occurred a year or more ago, was estimated in preference to mean age, based on the reported date of LMP, for two reasons. First, women may find it difficult to recall the date of last menses if this occurred some years earlier. Second, even if recall were perfectly accurate, such dates obtained from a cross-section of those in the age range would yield a misleadingly low mean. This is because the dates will be reported by those who have already experienced LMP, the ones who on average have experienced it earlier than those whose LMP is yet to occur.

The median age of reaching post-menopausal status was calculated after transforming the proportions who were post-menopausal at each age into probits,⁸ and assuming that the mean age of women in each age-year was the specified age plus 6 months (e.g. women who were 49 were assumed to be 49 years and 6 months). A median age of 50 years 9 months (50.74 years) (with a standard error of 1.9 months) was found and this gives the median age for LMP of 49 years 9 months. If the occurrence of LMP is normally distributed over the age range, the median and mean age are identical.

Probit analysis, rather than a crude estimate of the median by inspection of Table 5.9, was used in order to minimise the effects of sampling fluctuations. It can be seen, however, that the cruder method would give very much the same, although a less precise, result in this case.

⁷Only certain sterilisation procedures are reversible. Vasectomy which is increasingly popular is one of these (although not all attempts at reversal are successful). Laparoscopic sterilisation which is also becoming common is not reversible.

⁸D J Finney (1952) *Probit Analysis*, 2nd edn. Cambridge University Press, London.

6 Use of family planning services and contraception by women aged 16-55 in 1975 and the position of the older women

6.1 Introduction

Use of the services and the contraceptive practice of ever married women under 41 in 1975 were described in Chapters 2 and 4. In this chapter the age range covered is extended to include women up to the age of 55. This is done firstly to show the extent of service use and methods of contraception used by all married fecund women—all who are potential clients of the services. Secondly it is done to find out whether older women, those in their 40s and 50s have special birth control problems or particular difficulties in using the family planning services.

Because we are concerned here with differences between age groups the discussion as in the last chapter, centres on age cohorts rather than the marriage cohorts used in chapters 2 and 4.

6.2 Use of the family planning services by age

A quarter of all the ever-married women under 56 were current service users compared with over a third of those under 41, discussed in chapter 2. It was shown in the last chapter that a smaller proportion of the wider age range than of the younger women were at risk of unintended conception. Even so, rather fewer of all the women who were at risk than of the under 41s in the same state were current service users; about 40 per cent compared with some 50 per cent.

The reason for the difference, as can be inferred from the marriage cohort analysis in chapter 2, is

that (after the early 20s) service use declines over the age cohorts, and most steeply between the group in their late 30s and those in their early 40s (Table 6.1).

The proportion of women who had never used the services, conversely, increased with age after the early 20s. Only the groups in their 40s and 50s were more likely to be past than current users.

6.3 The acceptability of the services to older women

The comparatively low use of the services by older women, those in their 40s and 50s, raises the question of whether they were particularly inclined to suppose service use to be difficult or disconcerting. On the evidence described below the answer seems to be that on the whole they were not.

The older women, however, were rather less likely than the younger ones to know of an accessible source of contraceptive advice (77 per cent compared with 89 per cent) and a smaller proportion knew of a specific clinic. On this account only about 30 per cent of the older women knew of a clinic within less than 15 minutes walk, compared with 40 per cent of the younger ones. On the other hand the older women were no more likely than the younger ones to suppose that a journey to the clinic would take a quarter of an hour or more. About three quarters of both groups of women estimated that they could reach their GP in less than 15 minutes. Similar small proportions

Table 6.1 Use of family planning services by women aged 16-55, by age, fecund women only

Service use	All ages	Age-group							
		Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54
	%	%	%	%	%	%	%	%	%
Current GP user	19	25	28	22	24	20	10	9	4
Current clinic user	15	22	24	23	17	14	6	4	3
Other current users	2	2	4	2	3	2	1	..	0
Total current users	35	50	55	46	43	36	16	13	7
Past users	28	20	32	32	27	26	27	23	23
Total ever users	63	70	87	78	71	62	43	35	30
Never users	37	30	12	22	29	38	57	64	70
Not known	..	0	1	0	..	0	..	1	0
Base: fecund ever-married women under 56 = 100%		2,673*	40	351	576	459	414	380	315
									137

*Includes 1 woman aged 55.

of both groups thought it difficult to arrange a visit for contraceptive advice; about a quarter said this of clinics and about 10 per cent in the case of GPs (Table 6.2 and 6.3).

Table 6.2 Knowledge of sources of contraceptive advice, younger and older women, fecund women only

	Age-group*	
	16-40	40-55
	%	%
a Knows of:		
Accessible source	89	77
Other source	7	9
None	4	14
b Knows of:		
Clinic	84	70
None	16	27
Base: ever-married fecund women = 100%		
	1,913	833

*The two age groups 16-40 and 40-55 overlap by one year because the groupings were adopted for other purposes. This should make little difference to the comparisons.

Table 6.3 Accessibility of sources of contraceptive advice, estimated duration of journey times, younger and older women

	Age-group* and outlet			
	Clinic		GP	
	16-40	40-55	16-40	40-55
	%	%	%	%
a Duration of journey				
Under ½ hour	39	29	74	76
½ hour—	27	24	19	19
1 hour—	12	11	6	5
1 hour—	2	2	1	0
2 hours and over	..	..	0	0
Don't know	18	31	..	0
N.A.	2	3	..	..
b Considers a visit is difficult to arrange	27	23	12	8
Base: ever-married fecund women = 100%				
	1,913	833	1,913	833

*The two age groups 16-40 and 40-55 overlap by one year because the groupings were adopted for other purposes. This should make little difference to the comparisons.

Expectations and experience of embarrassment or lack of privacy during visits for contraceptive advice were quite similar for the two groups, although a slightly greater proportion of the older than younger women expected to be embarrassed. Almost exactly the same proportions (just over 10 per cent) of both groups said they would refuse or try to avoid an internal examination during a consultation for contraceptive advice and the only noteworthy difference between them was that the older women were rather more likely than the younger ones to expect sympathetic advice from each source (Table 6.4).

There were therefore only small differences between the two age groups in their perceptions of

Table 6.4 Attractiveness of the services, younger and older women, fecund women only

	Age group* and outlet			
	Clinic		GP	
	16-40	40-55	16-40	40-55
	%	%	%	%
a Service use is:				
Embarrassing				
Agree	22	29	21	24
Disagree	72	62	76	68
Don't know	3	5	1	2
Not known	3	5	3	5
Private enough				
Agree	65	59	92	90
Disagree	18	16	4	3
Don't know	13	20	1	2
Not known	4	5	3	5
The way to get sympathetic advice				
Agree	58	63	57	67
Disagree	24	14	31	17
Don't know	15	18	9	11
Not known	4	5	3	5
b Attitude to internal examination				
Would refuse	2	3	2	2
Avoid if possible	9	9	9	9
Dislike but accept	47	45	46	41
Not bothered	38	38	42	44
Other	2	2	..	1
Not known	2	3	1	3
Base: ever-married fecund women = 100%				
	1,913	833	1,913	833

*See note to Table 6.3.

the services, as measured in this survey. The only difference of any size (in expectations of sympathetic advice) was in the wrong direction to account for the older women's comparatively rare use of the services.

6.4 Current contraceptive use and age

Use of the pill, like use of the services, declined over the age cohorts after the early 20s, so that 64 per cent of the 20-24 year olds at risk were users but only 8 per cent of those aged 45-49 in the same condition. Use of the condom, on the other hand, increased with age up to 40-44 years but thereafter decreased. Amongst those under 35, use of the pill exceeded condom use, but from the late 30s onwards the converse was true (Table 6.5).

The practice of withdrawal, uncommon in all age groups, rose systematically with age after the early 20s. IUD use, which was also generally rare, was highest in the 25-39 year age range.

The examination of changes between 1970 and 1975 in chapter 4, indicate that these differences in contraceptive practice between the age cohorts are largely due to temporal trends rather than to changes with age in the method used. The dominance of temporal trends is borne out by the information derived from the women's contraceptive histories described in the next chapter.

Table 6.5 Current use of contraception by age, ever-married women aged 16-55 at risk

Method currently used	Age-group								
	All ages	< 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54
	%	%	%	%	%	%	%	%	%
Withdrawal	9	6	4	5	8	10	13	14	16
Pill	32	61	64	48	38	27	13	8	4
IUD	7	3	7	9	10	9	5	4	1
Diaphragm	3	0	1	2	4	4	2	3	7
Condom	29	9	16	23	28	32	40	34	30
Safe period	1	0	..	1	2	1	2	1	2
Abstinence	2	3	..	2	1	2	1	3	4
Other	5	0	2	4	1	5	6	8	3
None†	16	18	7	10	8	16	22	31	37
<i>Base: ever-married women at risk = 100%</i>									
	2,407*	33	273	458	414	404	374	313	137

*Includes one woman aged 55.

†Includes women not currently married—i.e. widowed, divorced or separated.

Perhaps one of the most striking features of Table 6.5 is the way in which non-use of contraception increases with age from the later 30s upwards, so that over a quarter (27 per cent) of the ever-married women at risk in their 40s and 50s were using no method. In part this is due to the age related increase in marriages broken by divorce, separation or death (see Table 5.1, chapter 5). Non-use of contraception by the women who were *currently* married and at risk is shown in Table 6.6 below. Amongst the women who were still married, at risk and aged 40-54, 21 per cent were using no method.

By definition the post-menopausal and otherwise sterile women were omitted from the group at risk of unintended conception, but the group did include some who were uncertain about their ability to conceive. If these too are excluded then 18 per cent of the remaining women aged 40-54 (who were currently married, at risk, and had no doubt that they could conceive) were using no method of contraception.¹ This is less dramatic than the 27 per cent of ever-married women at risk in the same age band, but surprisingly high in a group of women who are presumably particularly unlikely to welcome pregnancy.

¹Only 1 of the currently married women at risk under 40 who was using no method was uncertain about her ability to conceive.

Before going on to examine the circumstances of older non-users in detail, it is worth noting that non-use of contraception was also comparatively high amongst women aged under 20 (see Table 6.6). There were only 33 women at risk in the age group (all were currently married) and the apparently high proportion shown to be non-users could be due to the chances of sampling, but it is in line with other evidence that women who marry unusually young are relatively inefficient family planners.²

6.5 Older non-users of contraception

One of the questions the survey was intended to answer was whether older women had particular contraceptive difficulties. It seemed possible that the non-users of contraception aged 40-55 represented such difficulties in an acute form and were a group who needed but were not receiving family planning advice.

Childbirth after the age of 40 and particularly in recent years has been rare. During 1975, the year of the survey, there were only 4.8 births for every thousand women aged 40-44 compared with 63.3

²In 1970 and 1975 women who had married before they were 20 were more likely than others to have unplanned and unwanted pregnancies—see M. Bone—*Family Planning Services in England and Wales*—London, HMSO, 1973, p. 49, and Chapter 12 of this report.

Table 6.6 Non-use of contraception by currently married women at risk of unintended conception according to age

	Age-group								
	All ages	Under 20	20-24	25-29	30-34	35-39	40-44	45-49	50-54
	%	%	%	%	%	%	%	%	%
Currently uses no method	12	18	6	7	5	9	14	24	33
<i>Base: currently married women at risk = 100%</i>									
	2,275	33	270	442	398	375	345	283	128

for every thousand aged 15-44.³ It is apparent from Table 5.2 in the last chapter that a negligible proportion of women in the survey who were over 39 were pregnant. It therefore seemed likely that the older non-users were either mistaken in supposing they could conceive or else were not having intercourse.

To throw some light on the problem and to discover whether there was a pool of unmet need amongst the women, the interview schedules for about half the 110 or so cases involved were examined. The results of the examination suggested that there were three broad groups of women, not necessarily mutually exclusive, contributing to the pool.

Firstly there was a group of women who had had more—sometimes many more—pregnancies than average, who had never used contraception or had done so only sporadically. One of the women with a family already of Victorian proportions was uncertain whether she was pregnant again or experiencing the menopause, another said she was 'hoping for the best as always'. Some were enthusiastic about the family planning services which they saw as being for the young, and, whilst they regretted that they had lacked the same advantage in earlier life, they did not think of themselves as potential users. Besides women with very large families, the group included some who had had many abortions. But since we did not ask whether these were induced or spontaneous (see Chapter 9) it is impossible to say whether the women concerned had difficulty in restricting conception or in bearing live children. Some of the women in the group were perhaps the 'contraceptive casualties' of an earlier period when contraceptive information and choice were limited. These women were a minority of the cases examined.

Secondly, it appeared that some women or their husbands had been sub-fecund throughout their married lives. Typically these women had one or two pregnancies and had not had their first until after they had been married for 2 years or more despite non-use of contraception. The majority had never used contraception and the remainder had used it sporadically.

The third and largest group was composed of women who had evidently become sub-fecund with age or whose husbands had. These had had 2 to 4 pregnancies and had not had unusually long intervals between marriage and the end of the first pregnancy in the absence of contraception. Later in their lives, usually in their late 30s or early 40s they had abandoned the contraception they had used between or after child bearing.

About two thirds of the 62 cases examined could be allocated to one of the three 'pure' groups, ie

- (a) Women who had had 5 or more pregnancies and who had never used contraception or had done so only sporadically—9 cases.
- (b) Women who had 1 to 2 pregnancies of which the first, if any, had ended 2 or more years after marriage despite the non-use of contraception—10 cases.
- (c) Women who had 2 to 4 pregnancies the first of which had ended less than 2 years after marriage if no contraception had been used, and who had used no method without becoming pregnant for at least 1 year preceding interview—20 cases.

The remaining cases could not be allocated to one only of the defined groups, but about half were women who had not been pregnant for many years despite the non-use of contraception.⁴ If the latter women are added to groups b and c, then it seems that at least two thirds of the older non-users were in little danger of unintended conception, because they, or their husbands, were sub-fecund. Had they been interviewed at earlier stages of their lives, some would have been using contraception and some would have been trying to get pregnant. They appear as non-users in disproportionate numbers amongst the older women because they have presumably learnt over the years that their chances of becoming pregnant without contraception are low.

For example, suppose there are two couples, A and B, who married in the early 1950s and that during the second half of the 1950s they each have a second child. Both couples then use contraception for a time and then both decide to have a third child. Couple A have a third within a year of abandoning contraception. They decide not to have a fourth child and continue contraception until after the time of the survey in 1975. Couple B, on the other hand, do not conceive for a third time after abandoning contraception. Their inclination to have a third child passes with time, but experience has shown them that they are unlikely to do so and they remain non-users at the time of the survey.

Despite their experience, the women who were evidently sub-fecund or infecund were not prepared to say, when asked, that they would find it difficult or impossible to have another child if they wanted to, although some said (when asked about their current non-use of contraception) that they thought they were unlikely to get pregnant 'at my age'.

An incidental consequence of the evidence about sub-fecundity is that the true proportion of all

³Population Trends 6, Winter 1976, Table 18, p 34, London HMSO.

⁴The scheme was tested on the remaining 50 cases which yielded very similar results—i.e. 10 cases each in groups a and b, and 17 cases in group c leaving the remainder unallocated.

ever-married women who were infecund at the time of the survey must be higher than shown in the last chapter (Table 5.2) and particularly from the later 30s upwards. The true extent of infecundity in this age band cannot now be known because of the concentration of child bearing attempts in the earlier years of marriage and of the widespread use of contraception which is likely to mask the inability to conceive.

6.6 Is there a special contraceptive problem amongst older women?

It was suggested above that at least two thirds of the older non-users of contraception apparently at risk of unintended pregnancy in fact had little chance of conceiving. It seems therefore that much of the problem implied by non-use in the 40-55 year age band is illusory. It also seems likely that the smaller group of women who may be genuinely at risk—those who have been very fertile in the past—will diminish as the practice of effective contraception from the earliest years of marriage becomes increasingly commonplace; that is the problem may be one of generation rather than of age.

Before deciding that older women have no special birth control problems of concern to the family planning services there are a number of riders to these tentative conclusions. In the first place the very fertile and possibly still fecund older women who are non-users may be dwindling in number but are unlikely to disappear altogether in the near future. However, they present a difficulty for the services in that they evidently need special encouragement to use birth control methods, but because their numbers are few they are likely to be difficult to locate unless they actually become pregnant once more.

Next, at least some we classified as 'sub-fecund'

were not having intercourse.⁵ In one or two cases this was stated, in others implied, whilst a few hinted that intercourse had always been rare. For most of the small number involved it was not evident that this was due to fear of conception or that the women regretted the situation (although their husbands may have done). In at least one case, however, intercourse had been abandoned because of fear of pregnancy. It seems therefore that there is a, possibly very small, group of older couples who are avoiding intercourse because they dislike traditional contraceptive methods, are nervous of the newer ones or of asking for advice and are frightened of becoming pregnant. Like those with many children their problem may be related to their generation rather than to their age and if so their numbers are also likely to diminish in future. They too will be particularly difficult to locate.

There were also a few women who said they had been advised to discontinue or not to use the pill although it seemed that no other method of birth control had been suggested. This indicates a problem which may increase in the future as generations who have become accustomed to use oral contraceptives grow older. If it becomes common practice to advise women over 35 to discontinue the pill the need to make other acceptable and effective birth control methods available to them will grow.

Lastly, it may be that older women have other special birth control problems which are not shown by this limited and partly impressionistic investigation of non-users of contraception.

⁵The form of the interview questions on contraceptive practice was intended *inter alia* to persuade informants to report abstinence (if used) as a method of contraception. Clearly it did not always do so. Whether it is actually more sensible to regard couples not having intercourse as practising contraception or as infecund (at the time) must depend on the reason for abstinence.

7 How have the family planning services affected the use of contraception within marriage?

7.1 Introduction

It was shown in the first part of this report that use of the services increased between 1970 and 1975, that it had probably been doing so before 1970 and that the trend was almost certainly continuing in 1975. The purpose of the services is to enable people to avoid unwanted pregnancy, and a key question in assessing their performance is therefore whether increasing use of the services has resulted in improved control of fertility throughout the population. Greater control might be achieved by the more extensive use of contraception generally, by an increase in the use of the more effective methods or by some combination of the two. Such increases could be attributed to developments in the services if they occur or accelerate at about the time changes are made in the services. The changes in question are outlined in Chapter 1.

To find out whether these things have happened it is necessary to examine events over a longer period than the 5 years between the two surveys and to do so we obtained pregnancy and contraceptive histories from the married women interviewed in 1975 which cover up to 30 years of married life.

In this chapter changes over the period in the use of contraception and of specific methods will be considered; in chapter 8 we shall look at trends in contraceptive effectiveness and in chapter 9 we turn to the question of whether the methods provided through the services have affected pregnancy rates. The main problem throughout is to disentangle the effects of the services or the methods they provide from changes in couples' determination to control their fertility.

7.2 The method of analysis used

Because the interest lies in changes over time it is obviously necessary to relate contraceptive behaviour to specific calendar periods. But it is also important to take into account the particular stages of married life during which the behaviour occurred. This is partly because of the intrinsic interest of changes in contraceptive use and effectiveness over the period of family formation and partly to avoid any distorting effect such changes might have on apparent trends over time. The possibility of distortion arises mainly because

the experience covered by the earliest calendar periods will largely be of the earliest stage of marriage (of the oldest women in the sample); whilst experience in later calendar periods will be representative of all stages of the child bearing years.

For these reasons the women's histories were divided both at interview and in the analysis into dated inter-pregnancy intervals, the first of which begins at marriage and ends with the first conception, the second starting at the end of the first pregnancy and ending with the second conception, and so on. The last interval generally ends at the date of interview unless the informant was pregnant at the time. Women who were pregnant at marriage are considered to have had no first interval. No interval beyond the fourth (that following the third pregnancy) will be considered because the small numbers involved would limit the reliability of the results. In addition, if a woman had been married more than once, only intervals occurring in the most recent marriage were included.

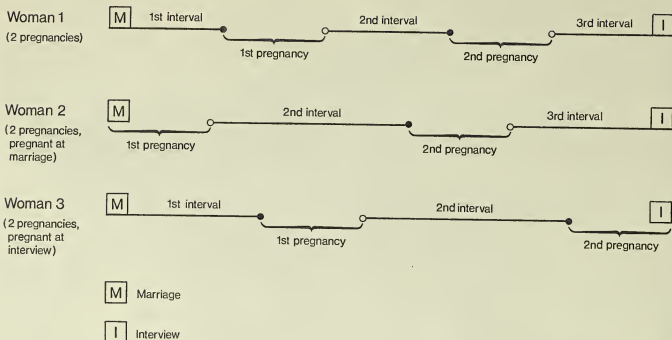
Three examples of the way the procedure works are shown diagrammatically below.

The ordered (first, second, etc) intervals are dated according to the 5 year calendar period in which they began (1946-50, 1951-1955, etc) to produce cohorts of ordered intervals similar to the marriage and age cohorts used in earlier chapters. In this chapter the interest is in behaviour (contraceptive use) within each of these groups of intervals; whilst the following two chapters are concerned with the planning status of pregnancies, if any, which terminated the intervals.

This procedure applied to the survey data qualifies the results for two reasons. Firstly it means that inter-pregnancy intervals rather than women are treated as the sampled population. But as a sample of intervals beginning during the 5 year periods of interest it is deficient in two ways:

- (a) equivalent intervals occurring at the same periods during earlier marriages to women married more than once are excluded
- (b) equivalent intervals occurring at the same periods to women who did not belong to the actual sampled population (especially those too old for inclusion) are excluded. The resulting distortion will be greatest for intervals

The ordering of pregnancy intervals - examples



occurring in the earliest calendar periods when women older than those sampled had the greatest chance of experiencing an equivalent interval. For example, a woman who married in 1941 at the age of 25—ie her 1st interval began in 1941—would have been 59 by the time of the survey in 1975 and would therefore have been omitted from the sample. For this reason no 1st or 2nd intervals beginning before 1946–1950, and no 3rd or 4th intervals beginning before 1951–55 will be considered.¹

Secondly, it is unlikely that the information obtained on pregnancy and contraceptive history over a period of up to 25 years will be entirely accurate and when there is evidence of misreporting this will be mentioned.

7.3 Long term changes in the use of all contraception

It was shown in chapter 4 that there had been little or no change in non-use of contraception between 1970 and 1975. Information about the longer period covered by the informants' histories shown in Table 7.1, however, suggests that there had been a massive increase in contraceptive use over the previous 25 years of which the greater part occurred after 1956–60. Table 7.1 shows the percentages of intervals in each group during which contraception was used. For example, the

first cell shows that contraception was used during 47 per cent of first intervals beginning in the years 1946–50. The numbers on which the percentages are based are given in the annex to this chapter.

The apparent increase in contraceptive use applied to all intervals considered (1st to 4th) but was greatest for the 1st, that between marriage and first pregnancy. For example, 50 per cent of the women whose 1st intervals began in 1951–55, but over 80 per cent of those whose 1st intervals began in 1971–1975, used contraception at that stage of their marriage. At the same time, whilst use in 1st intervals beginning in 1951–55 was considerably less than use in 2nd, 3rd and 4th intervals beginning in the same period, use during 1st intervals starting in 1971–75 was as great as that in contemporaneous 3rd and 4th intervals and actually higher than in current 2nd intervals.

(The increase in 1st interval contraceptive use between 1966–70 and 1971–75 was not evident from the information about current use given in Chapter 4 which was based on women 'at risk' (and therefore concealed changes in the proportion pregnant or planning pregnancy) and referred to a range of time points up to 4½ years after marriage, many of which did not relate to the 1st interval.)

Use increased throughout the period 1946–75 for all intervals, but there was an *acceleration* in the rate of increase for all intervals except the 4th between 1956–60 and 1961–65. For the 4th interval the acceleration occurred between 1961–65 and 1966–70.

¹In addition, some of the reported intervals will have occurred outside England and Wales and conversely some which occurred within the country will have been experienced by women who have since left and were therefore not in the sample of women.

Table 7.1 Percentages of inter-pregnancy intervals during which contraception was used, according to interval order and 5 year period in which interval began

Interval order	Years in which interval began					
	1946-50	1951-55	1956-60	1961-65	1966-70	1971-75
1	47	50	52	61	72	83
2	58	61	62	71	75	79
3		67	66	73	82	82
4		65	67	68	78	83

The figures in Table 7.1 therefore suggest that some impetus to the use of contraception, particularly during the first period of marriage, occurred in the 1960s. The timing of the upsurge in use (between 1956-60 and 1961-65 except for the 4th interval) indicates that the most likely candidate is the general introduction of the pill in 1961; that is the accelerated increase in use could have been due to the introduction of a highly acceptable method.

The figures, however, cover only 25 years and we cannot tell from them alone whether the trend from 1946-60 or that from 1961-75 was unusual.

Fortunately, there exists an earlier series comparable to the 1st interval figures in the Lewis-Fanning Report (of an enquiry carried out in 1946).³ When the two series are put together, they suggest a continuous increase in contraceptive use during the first stage of marriage from the beginning of the century which slackened only once—between 1946 and 1960—before resuming the secular rate of increase (Figure 7.1).

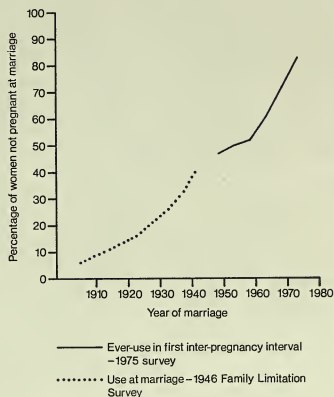
If the figures are taken at their face value, they imply that the role of the pill in the spread of contraceptive use during the first interval has been to steer it back on to a course followed since the turn of the century and from which it was diverted, only once, in the 1950s.

This interpretation of the figures, however, is qualified firstly by the differences between the samples used in the two enquiries and, secondly, by some evidence from them that the extent of contraceptive use was under-reported. The important points and the way they affect the evidence are:—

The 1975 sample was designed to be nationally representative, but the 1946 sample was of women who happened to be in hospital at the time (but excluded maternity cases) and compared with the general population was unusually fertile and included a disproportionate number of wives of manual workers. The disproportion appeared to be greatest amongst the women married in the earlier periods. Because

³Lewis-Fanning, *Family Limitation and its influence on human fertility during the past fifty years. Papers of the Royal Commission on Population*, Volume 1, London, HMSO, 1949.

Figure 7.1 Percentage of women using contraception at the earliest stage of marriage



of these biases the author of the report argued that the use of contraception by the 1946 sample was lower than in the general population.³

The effect of removing the supposed bias would be to raise the level of the curve for 1910-1942 and, presumably, more at its beginning than end.

- There was evidence of some concealment of the use of birth control by the 1946 sample, and its author believed this to be greatest for the earliest periods covered.⁴

The effect of removing the resulting error would again be to raise the level of the 1910-1942 curve and especially at its beginning.

- There was also evidence of some under-reporting of birth control by the 1975 sample for 1st

³E Lewis-Fanning *Op cit* pp 5-6.

⁴E Lewis-Fanning *Op cit* p 92.

intervals beginning in 1946-50 and 1951-56, since the pregnancy rates reported for these intervals by women who claimed to be using no method at the time were unusually low (see Chapter 10).

The effect of eliminating the consequent error would be to raise the levels of contraceptive use for 1946-50 and 1951-55.

If all these distortions occurred, an accurate picture of the trend in contraceptive use during 1st intervals over the first 75 years of the century, would show that use was higher at the beginning of the period than shown in figure 7.1, rose rather less steeply between then and 1950-55 and then remained unchanged or even declined in 1956-60 (the period during which fertility increased—see Chapter 1). As a result the steep increase from 1961-65 onwards would appear more abrupt than in the diagram and probably unique.

It therefore appears certain that something occurred in the 1960s to accelerate the long term trend in the use of contraception.

7.4 Changes in the use of specific methods of contraception

In this section we consider whether the event responsible for the acceleration in the spread of contraception could have been the general introduction of the pill in 1961, and begin by describing changes in the use of specific methods over the period 1946-75 which are shown in Table 7.2.

It should be noted that the percentages shown in the table refer to ever use of the specified methods during the interval. More than one method was used in 18 per cent of all intervals in which any method was used and therefore the specified method was not necessarily used during the 5 year period in which the interval concerned began. The apparent patterns over time are for this reason approximate but should be substantially correct because of the great preponderance of single-method intervals.

Use of the condom during 1st and 2nd intervals evidently reached its peak in the early 1960s and thereafter declined, but there appears to have been little change over the period in the extent of its use during subsequent intervals.

Use of the cap—never a popular method during the 25 years covered—evidently rose slightly during 1st and 2nd intervals and remained unchanged in 3rd and 4th intervals until the late 50s and early 60s and then decreased.

The reported use of withdrawal was also comparatively low, and gently but consistently declined for all interval orders.

The proportions of intervals during which IUDs were used were similarly small, but use increased steadily during the 1960s and early 70s. Throughout the period covered, the more pregnancies the couple had (up to the 3rd) the more likely they were to use the IUD.

By contrast to all the methods above, from the time

Table 7.2 Percentages of interpregnancy intervals during which various methods of contraception were used, according to interval order and 5 year period in which interval began

Interval order and method	Year in which interval began					
	1946-50	1951-55	1956-60	1961-65	1966-70	1971-75
	%	%	%	%	%	%
(a) Condom						
1	32	32	35	42	35	31
2	36	35	35	39	34	30
3		37	39	38	36	36
4		30	36	30	32	32
(b) Pill						
1	..	..	1	10	36	64
2	..	1	3	12	33	44
3		3	5	18	38	48
4		3	6	21	39	38
(c) Cap						
1	4	8	10	10	9	4
2	6	9	11	9	7	4
3		11	11	10	6	3
4		15	11	12	6	4
(d) IUD						
1		..	..	..	2	3
2		..	1	0	3	8
3			..	3	7	9
4		2	2	5	9	10
(e) Withdrawal						
1	11	10	10	10	9	8
2	16	16	13	15	9	8
3		20	15	14	13	6
4		19	17	12	11	7

the pill was generally introduced in the early 1960s, its use increased continuously and steeply. This was most marked for 1st intervals. Moreover, whilst in the first half of the 1960s, the pill was more likely to be used the higher the interval order—so that its use was commonest after the third pregnancy and rarest before the first—by 1971–75, use during the 1st interval considerably exceeded that during contemporaneous 2nd–4th intervals.

(It can be seen in Table 7.2 incidentally, that use of the pill was reported for a small proportion of intervals beginning before 1961. This does not necessarily indicate errors in reporting, since some of the intervals beginning before 1961 will have lasted at least until the 1960s and the pill may have been substituted for another method used at an earlier stage of the interval.)

The dramatic and unique increase in use of the pill from the time of its introduction suggests that it could indeed have played an important part in the exceptional increase in contraceptive use which started in intervals beginning in the early 1960s. The evidence of Table 7.2 described above, however, suggests an alternative interpretation.

It was shown that between the late 1950s and early 60s the reported use of the condom during 1st and 2nd intervals also increased at an unusual rate before beginning a decline lasting until the time of the survey. If this represents the real pattern of condom use, it could, together with the information about pill use, be read as follows:—

Between the late 1950s and early 60s, for some unknown reason, couples became more interested in controlling their fertility than they or their predecessors had been during the 1950s. This change in motivation was expressed partly by an unusual increase in use of the condom (probably the most effective method available before the

pill—see Chapter 8) and partly by the adoption of the newly introduced pill. As time passed and the pill became more widely discussed and accepted the new motivation was manifested through its increasing use by people who would otherwise have turned to the condom.

Yet another possibility, however, is that the pill was primarily responsible for the accelerated adoption of contraception from the early 1960s because it was itself a highly acceptable method, and that the short-lived spurt in condom use was the result of the public discussion of contraception which surrounded the introduction of the pill.

7.5 Discussion and summary

There is no evidence from the survey that any organisational changes in the family planning services made a specific impact on the long term spread of contraceptive use during inter-pregnancy intervals occurring before a fourth pregnancy. An unusual and possibly unprecedented acceleration of the trend, however, began in the early 1960s at about the time the pill became generally available. This suggests that the pill, because of its special acceptability was responsible for the surge in contraceptive use. A temporary swell in the use of the condom, however (then the most popular method) which began at the same time raises the possibility that the introduction of the pill coincided with a change in married couples' motivation to control their fertility which was subsequently expressed by an increasing preference for the pill, widely believed to be the most effective of reversible methods.

The absence of any identifiable impact of the services other than, possibly, through the distribution of the pill may not apply to intervals following the 4th and subsequent pregnancies, which were not examined.

Annex

Numbers of intervals of each order beginning in each 5 year period

Interval order	Year in which interval began					
	1946–50	1951–55	1956–60	1961–65	1966–70	1971–75
1	454	503	538	517	613	550
2	386	439	536	530	603	492
3		338	415	483	530	423
4		164	254	328	290	231

8 Have the methods of contraception provided by the services led to more effective contraception?

8.1 Introduction

In the last chapter we were unable to detect any specific impact of the organisational changes in the services described in chapter 1, on the spread of contraceptive use, and whilst the introduction of the pill may have been implicated, its role remains unproven. It is nevertheless likely that the services through the methods they provide, and in particular the pill, have improved the efficiency of contraceptive practice, and in this chapter the evidence from the survey for such an effect is considered. The analytical problem is again to distinguish changes in effectiveness due to the methods used from changes resulting from alterations from time to time in married couples' motivation to control pregnancy rates.

The reason for supposing that the rise in the use of the pill has led to increased contraceptive effectiveness is that almost all investigations covering a range of methods have shown it to be the most effective now available, apart from sterilisation. Non-appliance methods (withdrawal and the safe period) are usually found to be the least effective, whilst the barrier methods (condom and cap) which are theoretically highly effective, have usually fallen between the two extremes in practice and their failure rates have varied widely according to the population studied.¹

8.2 Failure rates—the method of measurement used

The method of measurement used affects the interpretation of the figures and the extent to which they can be compared with the results of other enquiries. The important points are the following:

The rates shown below in Tables 8.1 to 8.3 are cumulative failure rates per 100 women users over the first 12 months of use. Like sterilisation rates given in chapter 5, they differ from straightforward percentages because the base number changes as some women cease to be exposed to the risk of failure (eg. by stopping contraception

in order to get pregnant) or are removed from observation (i.e. by being interviewed) before a period of 12 months of use has elapsed.

A failure was deemed to have occurred if the woman conceived whilst a method was being used, or after the method had been abandoned for reasons other than the intention to get pregnant. This follows recent practice in the United States² and means that the rates shown are a result not only of the intrinsic effectiveness of the method concerned and the skill with which it is used, but also of the willingness of couples to persevere with its use. It is probably the best measure of effectiveness at a population level just because it takes into account people's willingness to continue using the method. A method which is highly effective while used, for example, has little contraceptive value if in practice it is quickly abandoned by large numbers of those who adopt it.

The 12 month period of exposure to risk of failure was taken to begin at marriage for the 1st interval^{3,4} and at the beginning of the third month following the end of the preceding pregnancy in subsequent intervals. The initial 2 months omitted from the period of exposure in 2nd–4th intervals was allowed for post-partum sterility.

Failure rates for all methods of contraception are based on the numbers of women using any method in the interval(s) concerned. Failure rates for specific methods are based on the number of women using the specified method alone during the interval(s) concerned. As noted in chapter 7, in 18 per cent of intervals during which contraception was used, more than one method was employed, and these intervals were excluded.

8.3 Overall failure rates for specified contraceptive methods for the period 1946–1975

The order of effectiveness found for the methods considered corresponded with that found in other

¹Failure rates found in a range of enquiries are quoted in: M Bone; Measures of contraceptive effectiveness and their uses; *Studies on Medical and Population Subjects*, No. 28, London HMSO 1975. More recently published findings derived from a study of women attending 17 English and Scottish clinics all given in: M Vessey, R Doll, R Peto, B Johnson and P Wiggins. A long-term follow-up study of women using different methods of contraception—An Interim Report. *J Biosoc Sci* (1976) 8, 373–427.

²e.g. N B Ryder—Contraceptive Failure in the US—*Family Planning Perspectives*, 5(3) 1973 pp 133–144.

³This may mean that 1st interval failure rates are spuriously low, i.e. some women will have been exposed to the risk of failure before marriage, and amongst the pre-nuptial exposed, those most prone to failure will have conceived before marriage.

⁴See Chapter 7 for definition of inter-pregnancy interval.

enquiries which have covered all the same methods. Oral contraceptives had been the most effective and withdrawal the least, whilst IUDs, and the barrier methods, fell in between (Table 8.1). It should be noted that the margin of error for the IUD is comparatively large, and that the relative positions of the IUD, condom and cap are open to question because of the size of the differences between them and of their standard errors.

Table 8.1 Contraceptive failure rates per 100 users for the first 12 months of use—all intervals combined

Method	Failure rate*
The pill	5
IUD	9
Condom	11
Cap	14
Withdrawal	20

*Standard errors for each figure were: pill—0.8; IUD—3.0; condom—0.8; cap—1.9; withdrawal—1.7. A further test of the difference between the failure rates of the IUD and condom over the whole 12 months confirmed that their performances did not differ significantly (see Annex 1 to chapter 9 for statistical techniques used).

Note: For the calculations women who had an operation resulting in sterility, whose marriage ended, or who stopped contraception in order to get pregnant were removed from the group still exposed to risk during the month in which the event occurred. Other informants who were sterile were removed from the interval ending with interview if they were aged under 45, and in the month they became 45 if they were 45 or older. Women who were interviewed before the end of 12 months of exposure were removed in the month of interview.

There seems, however, to be little doubt that the pill has been more effective than other methods and therefore that in distributing it, the family planning services have been encouraging or facilitating use of the most effective of reversible methods.

8.4 Trends in contraceptive failure rates 1946-1975

It was seen in the last chapter that use of the pill has steadily and steeply increased since the time of its introduction in the early 1960s, and in view of the foregoing evidence of its relatively low failure rate we should expect that general contraceptive failure rates had fallen during the 1960s and early

1970s as use of the pill became more and more widespread.

Table 8.2 shows that there was such a decline in the second half of the 1960s for 1st, 3rd and 4th intervals, and, for 2nd intervals, in the early 1970s. The decline in failure rates for 1st intervals, however, began before the late 60s, and is evident over the whole period covered.

This re-introduces the question of whether it was the pill which was responsible, as its use spread, for the decreasing failure rates, or whether, conversely, it was an increasing determination to control pregnancies which resulted in its successful record.

8.5 Trends in failure rates of the condom and pill
To examine the question stated above, it is necessary to look at trends in the failure rates for specific methods. If failure rates for methods other than the pill declined over the period concerned, as suggested by Table 8.2, then we shall be less confident that the trend was entirely due to the rise in use of the pill.

Amongst other methods only the condom was used by sufficient numbers of couples in each interval to make an examination of trends in its failure rates possible. For both methods, it is only possible to look at 1st-3rd intervals and which began in the 5 year periods shown because of the small numbers in other intervals.

Table 8.3(a) shows fluctuations but no apparent trend in failure rates for the condom as used in 2nd and 3rd intervals over the period 1951-75, but a decline in 1st interval rates between the early 50s and early 60s, followed by an increase. It should be noted, however, that failure rates for 3rd intervals beginning in 1956-60 and for 2nd and 3rd intervals beginning in 1971-75 were low, which confirms the evidence from other enquiries that low failure rates can be achieved with the condom.

Failure rates for the pill (in Table 8.3(b)) show no

Table 8.2 Contraceptive failure rates* per 100 users for the first 12 months of use during specified inter-pregnancy intervals—all methods combined

Interval order	Year in which interval began					
	1946-50	1951-55	1956-60	1961-65	1966-70	1971-75
1	22	18	15	14	11	7
2	13	11	12	13	13	6
3	—	14	8	12	7	5
4	—	10	10	12	7	7
*Standard errors are:	1946-50	1951-55	1956-60	1961-65	1966-70	1971-75
1	3.1	2.7	2.3	1.9	1.6	1.3
2	2.3	1.9	1.8	1.7	1.6	1.3
3	—	2.1	1.5	1.8	1.2	1.3
4	—	2.7	2.3	2.2	1.7	2.0

(See Note to Table 8.1).

Table 8.3 Contraceptive failure rates* per 100 users for the first 12 months of use during specified inter-pregnancy intervals for (a) condom, (b) pill

Interval order	Year in which interval began				
	1951-55	1956-60	1961-65	1966-70	1971-75
(a) Condom					
1	16	12	9	16	14
2	8	8	12	14	5
3	12	5	10	12	5
(b) Pill					
1				5	4
2			7	8	4
3			10	4	4
*Standard errors:					
Condom 1	3.5	3.0	2.3	3.8	5.2
2	2.3	2.3	2.7	3.1	3.0
3	3.9	1.6	2.7	3.4	3.0
Pill 1				2.1	1.6
2			4.6	2.3	1.7
3			4.8	1.9	2.0

(See Note to Table 8.1).

trend and, with the exception of 3rd intervals beginning in 1961-65, were consistently low. The exception was based on small numbers, and is subject to a wide margin of error.

The evidence from Tables 8.3 and 8.2 together might be interpreted as follows:

Failure rates in 2nd and 3rd intervals were reduced by the increasing adoption of the highly effective pill in the late 1960s, but in the early 1970s the experience of condom users suggests a rising determination to control pregnancy rates regardless of the method used. (Evidence from various sources indicate that most failures attributed to the condom are due to sporadic non-use.)

In the case of 1st intervals, couples were progressively reducing failure rates *before* the introduction of the pill, and as the pill became increasingly accepted, people who would otherwise have used the condom more and more conscientiously,

turned in growing numbers to the pill which may have enabled them to achieve low failure rates with less effort.⁵ Those who did not adopt the pill in the first interval, by contrast, being rather less concerned (it may be supposed) to control their pregnancy rate at that stage of marriage, experienced higher failure rates than the couples who had used the condom before the pill became available and accepted.

If this reading of the evidence is correct, it follows that the pill has been responsible for some but not all of the decline in contraceptive failure rates since its introduction and consequently that some of the reduction must have been due to a growing determination on the part of users of contraception to succeed in avoiding unintended pregnancies.

⁵Because occasional omissions to take the pill are less likely than occasional non-use of the condom at intercourse to result in conception. (See Chapter 10.)

9 The effect of contraception on pregnancy rates

9.1 Introduction

The two preceding chapters have shown that it is questionable although possible that the pill was the main cause of the surge in contraceptive use and of the decline in failure rates in the 1960s. Nevertheless, it seems to be beyond doubt that in recent years, for whatever reason, an ever-growing proportion of couples have been in a position to time and limit their pregnancies with some precision, to suit their tastes and circumstances.

In this chapter we shall try to find out whether the newly acquired means of control was used to space and limit pregnancies in a way which had for long been desired, i.e. the fall in pregnancy rates (which will shortly be shown) was due to improved contraception; or whether, on the contrary, people's targets were changing at the same time as use of effective contraception was spreading, i.e. the fall in pregnancy rates was the result of changed intentions.

To look for an answer, we shall consider first trends over 25 years in the rates of total pregnancies and of planned pregnancies [planned pregnancies are defined as those which were preceded by the use of contraception which was abandoned for the purpose of conception]. The working assumption for this part of the analysis will be that planned pregnancy rates represent the way all couples would have liked to space and limit their pregnancies at the time. Thus, if it were found, for example, that total pregnancy rates were much higher than planned rates at the beginning of the period, and that whilst planned rates remained unchanged, total rates declined to approach them in the 1970s; this might suggest that the fall in total rates had been brought about by improved contraceptive practice. Conversely, if total and planned pregnancy rates were the same throughout the 25 years and declined together this might imply that the decrease in total rates was due to changed objectives.

In the second part of the chapter we shall go on to consider the way the unwanted pregnancies represented by abortions account for any differences between total and planned pregnancy rates. Conclusions about the effects of the new methods of contraception on pregnancy rates will then be drawn from the results, together with the evidence about objectives derived from the two preceding chapters.

9.2 Pregnancy rates—the method used

Total pregnancy rates and planned pregnancy rates per hundred women were calculated by the method used for sterilisation and failure rates described in chapters 5 and 8 and in Annex 1 to this chapter. In this case the period covered was the 3 years following the beginning of each inter-pregnancy interval:¹ 3 years was chosen because during this time most of those who are going to have a further pregnancy will have done so.

The pregnancies were those which occurred within marriage so women were removed from the group exposed to risk if and when their (most recent) marriage ended. Women who experienced involuntary sterility were also removed from the 'at risk' group. Those who were sterilised (i.e. the informant or her husband had an operation to prevent further pregnancies) were not removed because they were in a similar position to couples who intended to practice contraception until the wife had reached the menopause.

Planned pregnancy rates are based on the couples who used contraception or who were sterilised during the period concerned.

The rates shown for intervals beginning in 1971–75 are provisional because many of them began less than three years before interview.

Further details are given in Annex 1 to this chapter.

9.3 Total pregnancy rates

Recent trends in marital fertility were described in Chapter 1. They show a rise in the fertility rates in the late 1950s until 1964 and a subsequent decline which steepened in the early 1970s. The pregnancy rates derived from the sampled women display a similar general pattern, but some variation according to interval order.²

Table 9.1 shows the cumulative pregnancy rates per 100 women for each of the first four inter-pregnancy intervals, according to the 5-year period in which the intervals began. The discussion will be

¹See Chapter 7, p 39 for definition of inter-pregnancy interval.

²Only pregnancy rates for 1st intervals can easily be compared with equivalent population data on birth rates, and this is done in Annex 2 to this chapter.

Table 9.1 Cumulative total pregnancy rates per 100 women at risk at 6 monthly intervals following the beginning of each inter-pregnancy interval

Months after beginning of interval		Year in which interval began											
		1951-55		1956-60		1961-65		1966-70		1971-75			
		%	Nos.	%	Nos.	%	Nos.	%	Nos.	%	Nos.		
1st interval													
6		26	477	32	505	27	485	23	577	12	530		
12		43		47		43		37		28			
18		51		58		52		47		36			
24		57		66		60		55		43			
30		62		69		65		61		50			
36		69	477	74	505	70	480	68	572	55	302		
2nd interval													
6		9	431	12	528	10	524	14	595	10	489		
12		21		27		28		31		24			
18		33		39		44		44		38			
24		44		52		57		58		50			
30		55		60		67		69		57			
36		62	429	67	527	74	521	75	594	62	302		
3rd interval													
6		8	333	9	411	9	480	10	527	8	419		
12		19		16		22		18		18			
18		28		30		30		25		23			
24		35		40		38		31		27			
30		40		45		44		36		30			
36		45	332	50	409	48	474	39	512	33	196		
4th interval													
6		6	162	5	247	12	307	9	283	8	245		
12		16		17		23		17		15			
18		24		27		29		21		20			
24		34		33		34		25		27			
30		42		38		40		28		28			
36		44	161	44	242	42	304	30	274	29	111		
Standard errors at 36 months		Interval		1951-55		1956-60		1961-65		1966-70		1971-75	
	1			2.1		2.0		2.1		2.0		2.7	
	2			2.3		2.1		1.9		1.8		2.8	
	3			2.7		2.5		2.3		2.1		2.9	
	4			3.9		3.2		2.8		2.8		3.5	

Note: Numbers are given for the beginnings and ends of the 3-year periods. For all 5 columns the numbers are depleted over the 3 years by dissolutions of marriage, operations resulting in sterility but not intended to sterilise, and the menopause. The numbers in the last column are also depleted by interviews occurring during the 3-year period.

confined to the rates at 36 months after the beginning of each interval, but the table shows that with few exceptions the differences and similarities between rates at 36 months were evident earlier.

The figures indicate a rise in pregnancy rates for intervals beginning in the late 1950s and then a decline for 1st, 3rd and 4th intervals throughout the 1960s and early 1970s, which was particularly steep for 1st intervals beginning in 1971-75. For example, rates for 1st intervals beginning in 1951-55 were 69 per hundred women at 36 months after marriage, rose to 74 per hundred for intervals of 1956-60, gradually fell to 68 for those in 1966-70, and then plunged to 55 in 1971-75.

Rates for 2nd intervals followed a different pattern: they increased until the late 1960s and then fell: they rose from 62 per hundred women for intervals beginning in 1951-55, to 75 per hundred for those of 1966-70, but then fell back to 62 in 1971-75.

It seems, therefore, that 1st (post-maritally conceived), 3rd and 4th pregnancies were increasingly deferred or averted from the early 1960s onwards. On the other hand, 2nd pregnancies evidently followed increasingly soon after 1st pregnancy from the early 1950s until the end of the 1960s and only began to be postponed in 1971-75.

9.4 Planned pregnancy rates

Table 9.2 presents corresponding information for planned pregnancy rates (ie intended pregnancies amongst contraceptive users). Over time the planned rates follow roughly similar patterns to those of the total pregnancy rates, and the most obvious difference between the two is that the planned rates were much lower than the total rates throughout the period covered.

What is perhaps less obvious, but is shown in Table 9.3 is that for 1st, 3rd and 4th intervals the difference between planned and total rates

Table 9.2 Cumulative planned pregnancy rates per 100 women at risk at 6 monthly intervals following the beginning of each inter-pregnancy interval

Months after beginning of interval		Year in which interval began									
		1951-55		1956-60		1961-65		1966-70		1971-75	
		%	Nos.	%	Nos.	%	Nos.	%	Nos.	%	Nos.
6 12 18 24 30 36	1st interval	4	242	9	272	6	310	7	426	4	457
		15		22		17		18		15	
		25		32		25		26		22	
		34		40		36		36		29	
		40		45		42		45		37	
		49	184	53	211	50	249	53	352	42	200
6 12 18 24 30 36	2nd interval	1	265	2	335	1	377	2	452	2	393
		5		8		11		10		11	
		13		17		24		21		24	
		21		28		37		38		36	
		33		37		51		52		44	
		41	201	45	255	61	289	61	354	49	187
6 12 18 24 30 36	3rd interval	1	229	1	278	1	353	2	436	2	355
		4		4		5		5		7	
		7		11		10		7		10	
		12		17		14		11		13	
		14		18		17		14		14	
		17	171	22	216	19	269	16	345	17	130
6 12 18 24 30 36	4th interval	0	107	0	174	0	220	2	231	1	215
		1		2		3		2		3	
		2		5		5		3		5	
		7		8		7		6		9	
		13		11		10		7		10	
		15	80	15	125	11	175	7	183	10	66
Standard errors at 36 months	Interval	1951-55		1956-60		1961-65		1966-70		1971-75	
	1	3.6		3.4		3.1		2.6		3.1	
	2	3.4		3.0		2.9		2.6		3.4	
	3	2.7		2.7		2.2		1.9		2.6	
	4	3.9		3.0		2.3		1.8		2.5	

Note: Numbers are given for the beginnings and ends of 3-year periods. Numbers are depleted over the 3-year periods as in note to Table 9.3, but also by contraceptive failures.

narrowed for intervals beginning in the late 1960s and again in the early 1970s. For 2nd intervals the difference was reduced in the early 1960s.

The reduction of the difference between total and planned rates suggest that at least some of the decline in the former in the 1960s and 1970s, may have been due to improved contraceptive practice rather than to people changing their targets.

This applies particularly over periods when planned rates rose or remained unchanged whilst total pregnancy rates fell; that is for 1st intervals between the first and second half of the 1960s, and for 3rd and 4th intervals between the late 1960s and early 1970s.

On the other hand, some declines in planned rates are evident and most notably for 1st and 2nd intervals between 1966-70 and 1971-75. At least part of the fall in the corresponding total pregnancy rates at the time must therefore have been due to changed intentions to postpone or limit pregnancies.

On the basis of this analysis, it would appear that changed intentions and improved contraceptive practice had each contributed to the recent fall in pregnancy rates: that changed intentions were probably mainly responsible for the deferral of 1st (post-maritally conceived) and 2nd pregnancies in the early 1970s, but that improved contraceptive practice to a large extent brought about the reduction in 3rd and 4th pregnancies between 1966 and 1975.

The planned pregnancy rates which contributed to this conclusion are, however, derived from the women who were practising contraception at the time and whose targets were not necessarily the same as those who were not. A couple who wish to have a baby as soon as possible after marriage, for example, will not use contraception and their intentions are not represented in the planned pregnancy rates used here. It follows that some of the difference between planned and total pregnancy rates must be due to differences between the intentions of contraceptive users and others. Similarly, some of the reduction in the difference

Table 9.3 The difference between total and planned pregnancy rates 3 years after the beginning of inter-pregnancy intervals, according to interval order and 5-year period in which interval began
Rate per 100 women
Year in which interval began and interval order

	1951-55								1956-60								1961-65								1966-70								1971-75							
	1		2		3		4		1		2		3		4		1		2		3		4		1		2		3		4		1		2		3		4	
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Total rates	69	62	45	44	74	67	50	44	70	74	48	48	39	30	55	62	49	17	10	13	16	19	29	33	42	49	55	62	30	39	16	61	75	39	16	7	42	49	17	10
Planned rates	49	41	17	15	53	45	22	15	50	61	19	11	53	61	15	11	53	61	15	11	53	61	15	11	53	61	15	11	53	61	15	11	53	61	15	11	53	61	15	11
Difference between planned and total rates (= 'unplanned' rates)	20	21	28	29	21	22	28	29	20	13	29	29	31	29	31	15	14	23	23	13	16	19	29	33	42	49	55	62	30	39	16	61	75	39	16	7	42	49	17	10

between the two sets of rates must have occurred because an increasing proportion of couples decided to postpone or avert further pregnancies and therefore adopted contraception. On the other hand, part of the difference between total and planned pregnancy rates is made up of pregnancies which were unintended and unwanted. Those represented by abortions are considered in the next section.

9.5 What abortions show about the targets of couples not using contraception successfully

Informants were asked how many pregnancies, if any, they had had which did not result in live births. The dates of the end of such pregnancies and their duration were recorded. Those which had lasted less than 7 months were counted as abortions. Informants were not asked whether the termination of the pregnancy had been spontaneous or induced.³ The abortions considered in this section are therefore of both kinds, but the trends shown below suggest that a majority of those which were reported for 3rd and 4th pregnancies were induced.

Table 9.4 shows the difference between rates for all reported pregnancies and 'surviving pregnancy' rates (those for pregnancies which lasted at least 7 months—ie which resulted in live or still births⁴) the difference being accounted for by abortions. It seems that abortions made negligible or no inroads on first and second pregnancy rates, but noticeably depleted third and fourth pregnancy rates, and the impact increased over successive 5 year periods.⁵ However, under-reporting may be greater for the earliest than later periods (because abortions were forgotten or concealed). If so, the increasing impact over time will have been less pronounced and the earlier pregnancy rates higher than appears.

The effect of reported abortions in bringing surviving pregnancy rates down to the level of planned pregnancy rates for 3rd and 4th intervals is suggested in Table 9.5. For example, whilst there was a 26 per cent difference between surviving and planned fourth pregnancy rates for 4th intervals beginning in 1951-55 the difference in 1971-75 was only 2 per cent which implies a decline in unplanned fourth births. The apparent convergence of planned and surviving pregnancy rates, however, should be seen as a very rough indication of what had been happening, since some of the planned pregnancies will have been termi-

³It was expected that some induced abortions would be reported as spontaneous. See Annex 3 to this chapter.

⁴Still births comprise only about 1% of total births.

⁵The trend and differences are evident from population statistics—see *The Registrar General's Statistical Reviews of England and Wales* and Supplements on Abortion—1968-73, and J Thompson, Fertility and Abortion inside and outside marriage—*Population Trends* 5, Autumn 1976—p 5.

Table 9.4 The difference between total pregnancy rates and rates of pregnancies which survived 7 months or more. Rates at 3 years after beginning of inter-pregnancy intervals according to interval order and 5-year period in which interval began

	Rate per 100 women of: Year in which interval began and interval order																			
	1951-55				1956-60				1961-65				1966-70				1971-75			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Total pregnancies	69	62	45	44	74	67	50	44	70	74	48	42	68	75	39	30	55	62	33	29
Pregnancies lasting 7 months and over	69	61	44	41	74	67	41	40	70	74	41	37	68	73	30	21	54	61	18	12
Difference between percentages (abortions—induced or spontaneous)	0	1	1	3	0	0	9	4	0	0	7	5	0	2	9	9	1	1	15	17

Table 9.5 The difference between planned pregnancy rates and rates of total pregnancies which survived 7 or more months. Rates 3 years after beginning of inter-pregnancy intervals, according to interval order and 5 year period in which interval began

Rate per 100 women of:	Year in which interval began and interval order																			
	1951-55				1956-60				1961-65				1966-70				1971-75			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Total pregnancies lasting 7 months and over	69	61	44	41	74	67	41	40	72	74	41	37	68	73	30	21	54	61	18	12
Planned pregnancies	49	41	17	15	53	45	22	15	50	61	19	11	53	61	16	7	42	49	17	10
Difference between percentages (unplanned births*)	20	20	27	26	21	22	19	25	22	13	22	26	15	12	14	14	12	12	1	2

*See footnote 7.

nated by spontaneous abortion,⁶ and planned and surviving pregnancies do not necessarily correspond with one another.⁷

Assuming that many of the reported abortions were induced, so that the recent narrowing of the gap between surviving and planned fourth pregnancies has been largely intentional, it seems that planned third and fourth pregnancy rates have latterly represented the targets of all couples at that stage of family building very well. This was at a time when abortions were fairly widely available and acceptable, compared with the past.

The correspondence between the planned rates (of couples using contraception) and the targets of others may have been less close in the past, but there is much evidence that for many years considerable proportions of third and fourth pregnancies have been unwanted.⁸ It therefore seems likely as the earlier analysis suggested that improved contraceptive practice from the late 1960s onwards rather than changed intentions, accounts for much of the narrowing of the difference between planned and total third and fourth pregnancy rates shown in Table 9.3.

The evidence of surviving pregnancy rates throws no further light on the causes of the fall in total first and second pregnancy rates, which seems to be principally due to changed intentions.

⁶Some of the spontaneous abortions are likely to have occurred amongst planned pregnancies so that the difference between rates of surviving fourth pregnancies and planned pregnancies which survived 7 months would be greater than 2%. Further evidence about unwanted pregnancies and births is given in Chapter 11.

⁷The order of surviving pregnancies does not necessarily correspond with the order of planned pregnancies, e.g. if a woman had 2 children, 2 miscarriages and then a planned third child, the third child would result from the third surviving pregnancy, but be the planned fifth pregnancy.

⁸Eg C M Langford—*Birth control practice and marital fertility in Great Britain*—Population Investigation Committee, 1976—p 43. A Cartwright—*Parents and Family Planning Services*—Routledge and Kegan Paul, 1970, p 13.

Annex 1

Method of calculating pregnancy and other rates
Pregnancy, planned pregnancy, sterilisation and failure rates were calculated by the life table method. This was earlier used for similar purposes on historical material obtained from cross-sectional surveys by Ryder & Westoff.^{*}

As stated in the main body of the report the advantage of the life table method over straight forward percentages in the calculation of cumu-

9.6 Conclusions

The present and two preceding chapters have been concerned with the role of recently introduced methods of contraception in the decline in pregnancy rates over the 1960s and early 1970s. The aim was to find out whether they had brought about a reduction which had been desired before they became available, or whether by contrast, their appearance had coincided with newly developed intentions to restrict and defer pregnancies.

There is reasonably convincing evidence that for some reason people's targets changed over the period covered and this is particularly true for first and second pregnancies. As time passed newly married couples, it appears, wanted the period between marriage and first pregnancy to become longer and longer, and most notably in the early 1970s. On the other hand, people wanted the second pregnancy to follow more quickly after the first in the 1960s than in the 1950s, and only sought to defer or avoid a second pregnancy in the early 1970s.

The evidence for a change of intentions in the case of third and fourth pregnancies is less apparent, and it is here in particular that the new methods may have brought about a long desired reduction in pregnancy rates. There is, moreover, a suggestion that first pregnancy rates changed more quickly in the late 1960s than intentions, so that part of their decline may be due to the independent effect of new methods of contraception.

There are therefore various, if not conclusive, indications that the new methods of contraception which became available in the 1960s enabled people to limit their third and fourth pregnancies in a way their predecessors had vainly wished to do.

lative rates is that it makes it possible to take account firstly of people who cease to be exposed to risk of the event of interest (eg a planned pregnancy) during the period covered, and secondly of people who are lost to observation (by being interviewed) before the end of the period of interest. As a result maximum use is made of all the information available, including episodes of exposure to risk which began only shortly before interview.

The cumulative rates used are the probabilities of the event occurring between the beginning of the period of exposure to risk and the end of the

^{*}N B Ryder and C F Westoff—*Reproduction in the United States 1965*—Princeton University Press—1971; N B Ryder—*Contraceptive Failure in the United States—Family Planning Perspectives*, 5, (3), 1973—133—144.

specified month. [They are the sum of the α_d 's from the conventional life table.† A single decrement life table was used.]

Standard errors were calculated by the method given by R G Potter‡ and are for the rate at the specified duration after the beginning of the interval. They can be used to decide whether the rate at that duration differs significantly from another rate at the same duration (the standard

†See, eg G W Barclay—*Techniques of Population Analysis*, 1958, London, Chapman and Hall—Chapter 4.

‡In R Friedman and J Takishita *Family Planning in Taiwan—an experiment in social change*—1969, Princeton University Press, Appendix X-2.

Annex 2

Comparison of first interval pregnancy rates from the sample with first interval live birth rates for the population. Only pregnancy rates for the first interval can easily be compared with data derived from birth registrations, but the first pregnancies reported in the survey differ from first births in a number of ways of which the following are the most important:

- they occur earlier than births,
- there are more of them than of births, because not all pregnancies result in live births,
- pre-maritally conceived pregnancies which ended after marriage were excluded from the first interval pregnancy rates derived from the survey sample,
- only the most recent marriages of women married more than once were included.

To increase the comparability of the survey and population figures:

- The proportion of women who had had a first pregnancy by 3 years after marriage is compared with the proportion who had had a first birth by 4 years after marriage.
- Pregnancies which terminated within 7 months of conception were excluded from the survey figures (this made almost no difference).

error of the difference being equal to the square root of the sum of the squared standard errors of each rate).

Differences between certain rates given in chapters 8 and 12 (Tables 8.1 (footnote), 12.7 and 12.8) were directly tested for statistical significance.§ In these cases the test was of the difference between the curves (produced by the cumulative rates at successive monthly intervals) and therefore indicates whether the performances of two groups differed significantly over the period as a whole.

§E A Gehan—A generalised Wilcoxon test for comparing arbitrarily singly-censored samples, *Biometrika*, 52, 203, (1965).

No steps were taken to overcome the problems at (c) and (d) above.

The pregnancy proportion (or rate) for marriages of 1961–65 looks considerably lower than the birth rates, but the difference seems to be accounted for by pre-marital conceptions which appear in the births but not in the pregnancy rates. By contrast the pregnancy rates for 1951–55 and 1956–60 look similar to the birth rates but seem to be rather high when allowance is made for pre-marital conceptions. Rough calculations suggest that the rates of post-maritally conceived first births at 4 years after marriage rose between the first and second half of the 1950s, remained unchanged in 1961–65 and then fell slightly (like the pregnancy rates at 3 years) in 1966–70.*

The differences in the 1950s could be due to the mis-reporting of pre-maritally conceived first births as post-maritally conceived, to the exclusion of earlier marriages of women married more than once or to a quirk of the sample.

The first pregnancy rates derived from the sample therefore appear to agree well with birth rates derived from the population for the 1960s, but less well for the 1950s.

*I am indebted to Dr S M Farid for this information.

Proportions of women who had experienced (a) a live birth within 4 years of marriage,† (b) a post-maritally conceived pregnancy which lasted 7 months or more, within 3 years of marriage

Year	a. Births	b. Pregnancies	Year	a. Births	b. Pregnancies
1951	69	69	1956	73	74
1952	68		1957	73	
1953	70		1958	75	
1954	70		1959	75	
1955	72		1960	77	
1961	76	70	1966	75	68
1962	77		1967	74	
1963	78		1968	71	
1964	77		1969		
1965	76		1970		

†Source: S M Farid. The Current Tempo of Fertility in England and Wales. *Studies on Medical and Population Subjects*, No 27, London, HMSO, 1970, (Parity Progression ratios, Table E1a, p 80).

Early natural pregnancy wastage There seems to be no way of estimating what the *reported* rates of spontaneous abortion should be. Estimates of the true rate of early natural foetal wastage have been very high (14 per cent to over 20 per cent of all pregnancies*) but much of the earliest loss is likely to go unrecognised by the woman concerned and therefore could not be reported at a later interview. A reported spontaneous abortion rate of 6 per cent to 7 per cent of pregnancies can be

calculated from the results of a recent survey of Old Order Amish Families in the United States.† The community concerned is one in which the women generally want large numbers of children and are unlikely to induce abortion. The correct equivalent England and Wales rates (ie of remembered and reported spontaneous abortions which have not been increased by the false inclusion of induced abortions) may be different.‡

*See e.g. C S C Tietze and C E Martin, 1957, Foetal deaths spontaneous and induced in the urban white population of the United States, *Population Studies*, 11 : 170-176. F E French and J M Bierman 1962, Probabilities of foetal mortality. *Public Health Rep.* 77 : 835-847).

†Figures given in: L J Resseguie, 1974. Pregnancy Wastage and Age of mother among the Amish. *Human Biology*, 46, 4, 633-639.

‡Preliminary findings from the *Family Formation Survey* (K Dunnell, awaiting publication) indicates that some induced abortions are reported as spontaneous, and some are not reported at all.

10 The time it takes to get pregnant

10.1 Introduction

The time it takes for married women to get pregnant is of interest to couples who wish to plan the spacing of their children and those in the family planning services who advise them. The answer will influence the point at which people who want a child at a particular time abandon contraception, even though the delay for an individual couple is unpredictable.

To be of maximum use the data should be related to the situation and characteristics, for example age, of the women at the time in question, but the numbers involved limit what can be done, and the discussion will be confined to the time taken to get pregnant firstly after contraception has been abandoned in order to conceive, and secondly when no contraception has been used during the inter-pregnancy interval concerned. It has been found previously that the time taken to conceive in the first case is briefer than in the second,¹ for reasons which will be discussed later, and it therefore seems advisable to consider the two circumstances separately.

10.2 The time taken to get pregnant after discontinuation of contraception

The proportions of women who were not pregnant at specified months after discontinuing contraception is shown in Table 10.1. Their experience is again related to inter-pregnancy interval order and time period so that trends over successive stages of family formation or over time will be apparent.

¹N B Ryder and C F Westoff—*Reproduction in the United States 1963*—Princeton University Press—Princeton, New Jersey, 1971—pp 316–319.

(a) **By interval order** There is some suggestion that the proportion not pregnant by given months after stopping contraception declined with advancing interval order. The apparent decline is not consistent for every 5 year period but is most noticeable for the more recent ones (1961–65 onwards), which are least likely to have been distorted by errors of memory. For example, for intervals beginning in 1966–70, the proportions not pregnant 3 months after stopping contraception were 40 per cent, 37 per cent and 31 per cent for the 1st, 2nd and 3rd intervals respectively. A similar trend was found in the United States by Westoff and Ryder² and a possible explanation is that the women who take longest to conceive in the earlier intervals either do not have further intervals (because they never conceive) or, if they do, do not use contraception subsequently (because they then know that they have difficulty in conceiving). Women who discontinue contraception to conceive in the later intervals would therefore include progressively higher proportions of the most fecund.

(b) **By time period** No trends over time are apparent, but for intervals beginning in 1971–75 there is some indication that a greater proportion of women than in previous years had not conceived within 3 and possibly within 6 months of discontinuing contraception. For example 49 per cent of those whose 1st interval began during the period 1971–75 had not conceived by 3 months compared with 37 per cent of the equivalent 1961–65 group.

²C F Westoff and N B Ryder *op cit.* p 319 Table X 1–18.

Table 10.1 The percentages of women who had not conceived by specified months after discontinuing contraception, according to order of inter-pregnancy interval and year in which interval began

No of months after beginning of interval	1951–55				1956–60				1961–65				1966–70				1971–75			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
1	73	71	76	81	80	73	73	83	73	71	67	55	75	74	75	*	82	79	76	*
3	39	41	34	*	45	40	40	*	37	35	33	*	40	37	31	*	49	46	44	*
6	21	20	*	*	27	20	26	*	21	17	*	*	24	17	*	*	26	27	*	*
9	17	15	*	*	23	14	*	*	14	9	*	*	16	7	*	*	16	17†	*	*
12	14	*	*	*	18	*	*	*	13	*	*	*	12	*	*	*	*	*	*	*

*Base number too small to yield reliable percentages.

†At 8 months.

(See Annex Table A for base numbers)

Evidence has been accumulating for some time that women who stop taking the pill in order to have a baby have to wait rather longer before conceiving than those who discontinue other methods. The difference between the two groups has recently been demonstrated very clearly by the results of a long term follow up study of clinic patients in England and Scotland.³

We now consider whether a similar difference was evident for the representative sample of women included in the survey and could therefore help to account for the increased delay to conception apparent for 1971-75.

(c) Method of contraception discontinued Table 10.2 shows that women who stopped taking the pill did have to wait a little longer to conceive than those who had stopped using the condom. For

Table 10.2 Percentages of women who had not conceived by specified intervals after stopping contraception in order to conceive; according to contraceptive method used and inter-pregnancy interval order

Months since contraception stopped	Percentages who had not conceived					
	1st Interval*			2nd-4th Interval*		
	Pill	Condom		Pill	Condom	
	% Nos.	% Nos.	% Nos.	% Nos.	% Nos.	% Nos.
1	83 195	72 187		81 231	71 289	
2	59	48		58	49	
3	47	35		46	33	
4	35	25		36	21	
5	30	24		30	17	
6	26	20		25	16	
7	20	18		18	12	
8	17	16		15	8	
9	12 181	14 186		13 218	7 286	

Note: Nos. are given for the beginnings and ends of the 9 months period. Nos. were depleted over the 9 months by dissolutions of marriage, the onset of sterility and interviews occurring before 9 months had elapsed.

*Intervals beginning in 1961-75.

example, amongst those in 1st intervals, 47 per cent of former pill users were not pregnant 3 months after discontinuation compared with only 35 per cent of former condom users. But the difference between the two groups had disappeared, for 1st intervals, by 7 months.

Vessey and his colleagues found a larger and more enduring difference between users of the pill and of other methods. They also showed it to be greatest and most persistent for nulliparous women (to whom the survey women in 1st intervals are roughly equivalent⁴): this was not

apparent amongst the survey women. The most obvious explanation for the differences between the findings of the two enquiries is that the survey information is less accurate than that from the long term follow-up study, since the former depended to a much greater extent on informants' memories of events over some years. But it may be a difference in the populations covered by the two enquiries which accounts for the particularly long delay to conception for nulliparous women who had used the pill, found in the follow-up study but not in the survey. Whilst the survey sample was representative of all ever-married women in the country,⁵ only those aged 25-39 at the outset were included in the follow-up study and the mean age of the nulliparous women in the latter at the time of stopping contraception was about 28 years. The average age of once married women in the population at first live birth was around 24 years in the early 1970s.⁶ The nulliparous women investigated by Vessey and others were therefore unusually old at the time they began to try to have their first child.⁷

Whatever the exact dimension of the difference in the delay to conception between former pill and other contraceptive users, the important point is that the difference is visible in a nationally representative sample of married women. This confirms the need for couples using the pill to allow more time than others for becoming pregnant after discontinuing contraception.

10.3 The effect of the delay on planned pregnancy rates

The planned pregnancy rates discussed in Chapter 9 were taken to be the *intended* pregnancy rates amongst contraceptive users. But if the increasing use of the pill has resulted in some unforeseen delay in conception the planned rates may be somewhat lower than intended.

Table 10.3 shows that the planned pregnancy rates for women who used the pill were a little lower than for those who used the condom. For example, 18 months after the start of 1st intervals beginning in 1971-75, 37 per cent of condom users compared with 32 per cent of pill users had had a planned first pregnancy. It is possible that other factors contributed to the difference between the rates for the two groups, but it must in part have been due

³The bias towards younger ages for earlier intervals discussed in Chapter 7 will not have affected intervals beginning in the 1960s and 70s which are the main concern here.

⁴Office of Population Censuses & Surveys—*Birth Statistics 1974—series FMI no. 1*. London, HMSO, 1977—Table 1.6 p. 15.

⁷The age criterion for admission to the longer term follow-up study was determined by the main concern of the investigation with the morbidity associated with different contraceptive methods (Vessey *et al* *op cit* pp 376-377).

Table 10.3 Cumulative planned pregnancy rates per 100 women at risk according to inter-pregnancy interval order and year in which interval began—pill and condom users compared

No of months after beginning of interval	Interval order and year in which interval began					
	1966-70			1971-75		
	1	2	3	1	2	3
Pill users	%	%	%	%	%	%
6	4	1	0	6	1	2
12	18	7	3	21	11	7
18	28	14	5	32	27	9
24	39	36	12	38	37	13
30	50	52	16	47	46	17
36	60	63	19	51	49	23
Condom users						
6	12	4	6	4	4	7
12	28	12	11	27	18	17
18	38	29	17	37	34	19
24	44	43	20	*	47	19
30	54	57	24	*	*	21
36	63	66	24	*	*	21†

*Numbers are too small to yield reliable percentages.

†At 35 months.

to the difference between methods in the delay to conception.

The unintentional depression of what are called in this report 'planned pregnancy rates' must have occurred latterly in all intervals as use of the pill increased, but it is likely to have affected the rates for 1st intervals most because, as was shown in Chapter 7, use of the pill grew fastest and in 1971-75 was commonest in the 1st interval.

It follows that some part of the most recent decline in both planned and total 1st interval pregnancy rates, shown in Chapter 9, must have been unintentional: that the deferral of first (post-maritally conceived) pregnancies has to some, perhaps small, extent been accidental.⁸

⁸This assumes that people have not realised that they will have to wait somewhat longer to conceive after discontinuing the pill than after stopping other methods, and made use of the knowledge in their planning.

10.4 The time taken to get pregnant when no contraception has been used during interval

The percentages of non-users of contraception not pregnant at given periods after the beginning of each interval are shown in Table 10.4. Comparison with Table 10.1 shows that on the whole non-users took longer to get pregnant than contraceptive users who had stopped using contraception in order to conceive. For example, 9 months after the start of 1st intervals beginning in 1966-70, 42 per cent of non-users were still not pregnant compared with only 16 per cent of former contraceptive users.

As mentioned at the beginning of the chapter a similar difference between users and non-users was found in the United States. There are at least two possible reasons for the difference. Firstly the non-users of contraception may include a disproportionate number of sub-fertile or infertile women. Those who learn from pre-marital sexual experience without contraception that they do not get pregnant, for example, will presumably be less likely than others to use contraception after marriage in the 1st interval. Similarly, those who use contraception in the 1st interval, but find difficulty in conceiving after its discontinuation will be particularly inclined not to use a method once they have had a 1st pregnancy, and so on.

Secondly, it is possible that some of those who said they were not using contraception during a particular interval were mistaken. They may for example have been using withdrawal and have forgotten the fact or not counted it as contraception.⁹ There is no simple way of finding out whether such under-reporting occurred generally, but there is some suggestion that it happened for intervals beginning in the late 1940s and early 1950s. For example, over 40 per cent of the women whose 1st intervals began at that time had not become pregnant by 12 months after the beginning of the interval compared with 36 per cent or less in

⁹Although every effort was made in the interview to persuade informants to include withdrawal as a contraceptive method.

Table 10.4 Percentages of women who had not conceived by specified months after beginning of inter-pregnancy intervals, according to order of interval and 5-year period in which interval began—Non-use intervals.

No. of months after beginning of interval	Interval order and year in which interval began																	
	1946-50			1951-55			1956-60			1961-65			1966-70			1971-75		
	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
1	93	100		90	100	99	84	99	98	90	98	100	87	98	97	86	96	98
3	77	96		78	97	97	68	92	91	68	90	94	72	83	81	78	89	90
6	61	79		65	82	86	51	77	80	51	77	78	51	59	64	62	66	63
9	50	65		55	74	79	43	66	76	36	61	72	42	44	54	49	53	38†
12	41	60		46	66	71	36	56	70	32	54	61	34	36	50	36	43	*

*Base number too small to yield reliable percentage.

†At 8 months.

(See Annex Table B for base numbers)

later 1st intervals. There is therefore a possibility that contraceptive use was disproportionately under-reported for that period, as mentioned in Chapter 7.

10.5 Conclusions

The most important finding of this chapter is the confirmation that women who use the pill take rather longer to get pregnant after its discontinuation than those who stop using other methods of contraception.

The difference has been demonstrated previously,¹⁰

¹⁰Vessey *et al*, *op cit*.

but not in a sample representing all married women in the child bearing years. It is clearly necessary information for users of the pill so that they can take it into account when planning to get pregnant.

A possible implication of the difference between users of the pill and other methods is that some, perhaps small, part of the recent decline in pregnancy rates discussed in Chapter 9 has been an accidental consequence of the increasing use of the pill. This seems most likely in the case of first pregnancy rates, since use of the pill was latterly commonest in the interval between marriage and first pregnancy.

Annex

Numbers on which percentages are based at beginnings and ends of periods covered.

Table A. Former users of any contraceptive method (see Table 10.1)

No of months after beginning of interval	Interval order and 5-year period in which interval began															
	1951-55				1956-60				1961-65				1966-70			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
0	139	126	51	21	164	162	75	29	190	209	76	29	250	257	84	
1				21				29				29				
3			50								76				84	
6							74									47
9		125				161				209				257		
12	139				164				190				250			135*

*At 8 months.

B. Non-use intervals (see Table 10.4)

No. of months after beginning of interval	Interval order and 5-year period in which interval began											
	1951-55			1956-60			1961-65			1966-70		
	1	2	3	1	2	3	1	2	3	1	2	3
	%	%	%	%	%	%	%	%	%	%	%	%
0	235	166	104	233	193	134	175	147	128	151	143	95
1												
3												
6												
9												
12	235	166	104	233	193	132	173	147	124	150	143	91
										66	79	45*

*At 8 months.

11 More about sterilisation

11.1 Introduction

It was shown in chapter 5 that sterilisation rates had greatly increased over the 10 years before 1975 and that this was particularly the case for women under 35. This has important implications for the future call on the family planning services as suggested earlier and for future fertility no matter what the experience of the couples concerned before sterilisation. But it is also important to know the way sterilisation is being used and specifically whether it is the method of those who have had more pregnancies or children than average and more than they wish, or whether it is increasingly a preferred means of contraception for couples who have had just the number of children they want.

According to the answer, the effects of sterilisation must be evaluated by comparison with those of further unwanted pregnancies, or (in the second case) by comparison with those of effective reversible means of contraception.

11.2 The relationship between sterilisation and previous pregnancy experience

Couples who had experienced an excessive

number of pregnancies were more likely than others to have been sterilised, and this can be illustrated in two ways:

Firstly, the more children a woman had, the more probable that she or her husband had been sterilised so that, for example, just over 10 per cent of couples with 2 children had been sterilised, but a third of those with 5 (Table 11.1). Similarly the more pregnancies a woman had had the more likely that one member of the couple had been sterilised (Table 11.2).

However, whilst 70 per cent of all sterilisations were of couples with less than 4 children, only 50 per cent were of those with less than 4 pregnancies. The difference arises because a higher proportion of women who had experienced a wasted pregnancy (abortion or stillbirth) than others belonged to a sterilised couple: 9 per cent of the women reporting no wasted pregnancy, 14 per cent of those reporting one and 22 per cent with more than one were members of sterilised couples (Table 11.3). As noted in the last chapter, induced and spontaneous abortions were not distinguished and in this case the inference that sterilisations were clustered amongst women who

Table 11.1 Whether informant (or husband) had been sterilised according to the number of their living children (excluding adopted etc. children)

	Number of living children							
	All numbers	0	1	2	3	4	5	Over 5
	%	%	%	%	%	%	%	%
Sterilised	11	1	3	11	18	23	34	33
Not sterilised	89	99	97	89	82	76	66	67
<i>Base: ever-married women 16-55 = 100%</i>								
	3,898	649	833	1,301	648	245	115	104

Table 11.2 Whether informant (or husband) had been sterilised according to number of pregnancies

	Number of pregnancies							
	All numbers	0	1	2	3	4	5	Over 5
	%	%	%	%	%	%	%	%
Sterilised	11	1	1	8	14	20	23	36
Not sterilised	89	99	99	92	86	79	77	64
<i>Base: ever-married women 16-55 = 100%</i>								
	3,898	506	713	1,116	741	404	191	227

Table 11.3 Whether informant (or husband) had been sterilised according to experience of pregnancy wastage

	Pregnancy experience		
	No wasted pregnancies	One wasted pregnancy	More than one wasted pregnancy
	%	%	%
Not sterilised	86	80	68
Sterilised	9	14	22
Other operation*	5	6	10
Total operations	14	20	32
<i>Base: ever-married women 16-55 = 100%</i>			
	2,842	764	292

*Figures for other operations resulting in sterility are given in this table because of the interest of their apparent relationship with pregnancy wastage. On other tables (except 10.5) 'other operations' are included in the 'not sterilised' group.

had experienced excess pregnancies must be open to question.

Secondly, however, women who had regretted their last pregnancy, and to a lesser extent those who wished it had occurred earlier, were more likely than others to be in the sterilised-couple group, so that nearly a quarter of the women who said they had not wanted their last pregnancy compared with only about 10 per cent of those who had welcomed it were involved (Table 11.4).

To some extent, therefore, it seems that sterilisation had been used when other means of controlling fertility had failed or gone unused, and the couples concerned had already had more

pregnancies than they wanted. But although these couples were the most likely to have been sterilised, the greatest number of sterilisations had been of other couples who comprise the great majority of the population covered.

11.3 The changing role of sterilisation

(a) **The changing impact of sterilisation** In both 1970 and 1975 the proportion of women who, or whose husbands, had been sterilised increased with the number of their children, but for each number (other than zero) the proportion sterilised in the 1975 survey greatly exceeded the corresponding 1970 figure (Table 11.5).

Table 11.4 Whether informant (or husband) had been sterilised according to informants' reported reaction to last pregnancy

	Reactions to last pregnancy			
	Pleased	Wished it had happened earlier	Wished it had happened later	Sorry it happened at all (resulted)
	%	%	%	%
Not sterilised	91	88	92	77
Sterilised	9	12	8	23
<i>Base: ever-married women 16-55 = 100%</i>				
	2,193	195	185	645

Table 11.5 Sterilisations according to number of children 1970 and 1975

	Number of living children and year of survey															
	All numbers		0		1		2		3		4		Over 4			
	1970	1975	1970	1975	1970	1975	1970	1975	1970	1975	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Not sterilised	94	86	97	99	99	99	96	96	84	90	72	86	58	69	48	48
Sterilised	4	13	1	1	..	4	2	13	8	26	12	37	24	49	7	4
Other operation*	2	2	2	..	1	..	2	2	1	2	2	2	4	7	4	4
Total operations	6	14	3	1	1	4	4	16	9	28	14	42	31	52		
<i>Base: ever-married women under 41 = 100%</i>																
	2,520	2,344	935	469	543	530	834	805	436	341	155	113	117	84		

*Other operations resulting in sterility are included on this table to allow comparisons between the two sets of figures. On other tables (except 11.3) 'other operations' are included in the 'not sterilised' group.

The change is put into a different perspective by the sterilisation rates for the first 4 inter-pregnancy intervals beginning in successive 5-year periods. (As defined in Chapter 7, the 1st interval is that between marriage and the beginning of the first pregnancy or interview, whichever occurred first; the second interval the period between the end of the first pregnancy and the beginning of the second (or interview), and so on.) The sterilisation rates for the first 4 intervals also demonstrate the recent rise in the incidence of sterilisation (Table 11.6) but the interesting point here—most noticeable for the 4th interval—is that, whereas the 1966–70 rates continued to rise over the 5 years following the end of the preceding (third) pregnancy, that for 1971–75 appeared to level off at 2 years after the third pregnancy. As a result it seems that over half of those who were going to be sterilised following a third pregnancy which ended in 1971–75 had had the operation within 6 months of the event. By contrast it was not until at least 3 years after third pregnancies ending in 1966–70 that half of the couples to be involved had been sterilised.

For reasons given in chapter 7, it is not possible to give rates for 5th or later intervals, but a cruder

analysis of sterilisations following intervals beginning in 1966–70 indicates that the 'delay' between the end of the last pregnancy and sterilisation at that period applied mainly to those with less than four pregnancies: whilst just under half the sterilised couples who had had less than four pregnancies had the operation within 3 years, well over 80 per cent of the sterilised who had had four or more were sterilised within 3 years (Table 11.7).

Because the period of observation for those whose last interval began in 1971–75 is curtailed (by interview) a similar analysis could be misleading. However, a rather greater proportion of the early (within 3 years) sterilisations following last pregnancies ending in 1971–75 than in 1966–70 were of couples who had had less than four pregnancies: 49 per cent and 40 per cent respectively (Table 11.8).

The same form of analysis also linked the present evidence with that of Chapter 5, and suggested that the early sterilisations were increasingly of couples who not only had few pregnancies but in which the wife was still young. In particular, under a quarter of the sterilisations occurring within

Table 11.6 Cumulative percentages of women at risk sterilised at specified months following beginning of the first four inter-pregnancy intervals, according to 5 year period in which interval began

No. of months following beginning of interval	Year in which last interval began and order of interval											
	1961-65				1966-70				1971-75			
	1	2	3	4	1	2	3	4	1	2	3	4
	%	%	%	%	%	%	%	%	%	%	%	%
3	0	0	0	0	..	0	..	3	..	1	3	11
6	0	0	0	..	..	0	1	4	..	1	4	16
12	0	0	..	..	..	..	2	4	1	1	7	18
18	0	0	..	..	..	..	2	6	1	1	8	18
24	0	0	..	..	..	..	2	6	1	1	10	21
30	0	0	..	..	..	..	3	7	2	1	11	21
36	0	0	..	1	..	..	4	9	2	2	14	21
42	0	0	..	1	..	..	4	10	2	2	14	21
48	0	0	..	1	..	..	5	11	2	2	14	21*
54	0	0	..	1	..	1	5	13				
60	0	0	..	2	..	1	6	13				

*At 45 months.

Note: For definition of inter-pregnancy interval see Chapter 7, p 39. For method of calculation of rates see Chapter 9, Annex 1.

Table 11.7 Percentages of sterilised couples who had operation within 3 years of beginning of last inter-pregnancy interval by number of pregnancies and according to 5 year period in which last interval began

Time following beginning of interval	Year in which last interval began and number of pregnancies			
	1961-65		1966-70	
	Under 4	4 or more	Under 4	4 or more
	%	%	%	%
Less than three years	9	67	45	86
3 years or more	91	33	55	14
Base: number of sterilisations = 100%				
	32	18	73	58

Table 11.8 Percentages of the sterilisations occurring within 3 years of beginning of inter-pregnancy interval which were of women with less than 4 pregnancies according to 5-year period in which interval began.

Number of pregnancies	Year in which last interval began		
	1961-65	1966-70	1971-75
	%	%	%
less than 4	20	40	49
4 or more	80	60	51

Base: no. of sterilisations occurring within 3 years of beginning of interval = 100%

	15	83	145
--	----	----	-----

3 years of intervals beginning in 1966-70 were of couples including a wife under 30 who had had less than four pregnancies, but nearly a third of the early sterilisations for intervals beginning in 1971-75 fell into the same category.

(b) **The changing composition of the sterilised group** Presumably, as a result of the 'delayed' sterilisations of those who had completed average sized families in the late 1960s, and because of the early sterilisation of couples who had reached the same stage in 1971-75, the composition of successive cohorts of sterilised couples was changing. Table 11.9 shows that whilst under 40 per cent of the couples sterilised in 1966-70 had had less than four pregnancies, nearly 60 per cent of those sterilised in 1971-75 were in the same position.

Table 11.9 Percentages of sterilisations occurring to couples who had had different numbers of pregnancies, according to 5-year period in which sterilisation occurred.

Number of pregnancies	Year of sterilisation		
	1961-65	1966-70	1971-75
	%	%	%
0	0	0	1
1	0	1	3
2	4	13	29
3	4	24	26
4	17	22	19
5	22	14	8
Over 5	52	26	14

Base: no. of sterilisations = 100%

	23	116	259
--	----	-----	-----

Because successive cohorts of the sterilised were increasingly made up of people with few pregnancies, a declining proportion of them had had more pregnancies than they wanted at the time of operation. Thus 47 per cent of those sterilised in 1966-70 regretted their last pregnancy, but only 29 per cent of the women involved in 1971-75 (Table 11.10). Similarly, 46 per cent of the couples sterilised in the late 1960s had experienced a wasted pregnancy, but only 37 per cent of those having the operation in the early 1970s (Table 11.11).

Table 11.10 Percentages of sterilisations occurring to couples in which the wife had regretted last pregnancy, according to 5-year period in which sterilisation occurred.

Reported reaction to last pregnancy	Year of sterilisation		
	1961-65	1966-70	1971-75
	%	%	%
Pleased	35	40	55
Sorry it happened at all (regretted)	65	47	29
Other	0	14	16

Base: no. of sterilisations = 100%

	23	116	259
--	----	-----	-----

Table 11.11 Percentages of sterilisations occurring to couples who had had wasted pregnancies, according to 5-year period in which sterilisation occurred.

Pregnancy experience	Year of sterilisation		
	1961-65	1966-70	1971-75
	%	%	%
No wasted pregnancies	56	54	62
One wasted pregnancy	17	32	22
More than one wasted pregnancy	26	14	15

Base: no. of sterilisations = 100%

	23	116	259
--	----	-----	-----

The proportions providing evidence of excess pregnancies (regretted or wasted) were higher even amongst the most recently sterilised than in the sample as a whole (see next chapter). Nevertheless, the results suggest that sterilisation was becoming less of a last resort for the desperate and more of a chosen method for couples who had just achieved the number of children they thought sufficient.¹

11.4 Conclusions

Sterilisation was therefore not only spreading but increasingly impinging on young couples who had had few pregnancies and, it seems, quite soon after they had decided that their second or third baby was to be the last. In view of this trend, which may be continuing, it appears important that more be known about any undesirable consequences of sterilisation including the failure rates and the likelihood that those involved will later regret their action. With this knowledge people who contemplate sterilisation in future and those who advise them will be in a better position than is at present possible to assess its advantages and disadvantages in comparison with other methods of contraception.

¹The conclusion would be sounder if based on sterilisation rates for those who had had an 'excess' or 'non-excess' pregnancy at different periods, to take account of the numbers of women at risk in each group. But in one case (regretted pregnancies) the information is available only for the last pregnancy before interview, and in the other (wasted pregnancies) the numbers are too small for the analysis.

12 Social class and other differences in fertility and contraceptive behaviour

12.1 Introduction

Some groups of women, for example those with husbands in manual occupations, have for long displayed higher than average fertility. The 1970 survey indicated that the same groups were also most likely to report excess fertility in the sense that a higher than average proportion of their pregnancies were said to have been unplanned or unwanted. Amongst the wives of manual workers those in classes IV and V were particularly affected and the other groups concerned were women who had married before the age of 20, and those who had conceived before marriage.¹

The family planning services are intended to help people to avoid unwanted pregnancies, whatever their social, economic or other circumstances, and one indication of the success of the services might be a reduction of social class and other inter-group differences in excess fertility. The purposes of this chapter are to find out whether the groups described still had, in 1975, an above average risk of excess fertility and therefore merit special attention by the services; if so, whether the difference between these groups and other women had decreased, and whether any such decrease found could be ascribed to the activities of the family planning services.

12.2 Do high risk groups still exist?

In 1975, the groups identified in 1970 as having a high risk of excess fertility were still distinguished from other women by their larger family size and greater tendency to report that their last preg-

nancy was unwanted. This was true for the whole sample, but because comparisons will shortly be made with the 1970 findings the evidence in this section comes from the corresponding 1975 group—women under 41 at interview.

Table 12.1 shows the relationship between family size and social class in the 1975 sample: 4 per cent of the non-manual group but 11 per cent of the manual group had more than three children. Amongst the high risk groups, 14 per cent or more of those in the high risk groups had more than three children, but only 4 per cent of the women with no high risk characteristics (Table 12.2). The tendency of the manual and high risk groups to have larger families than other women held within every age group.

Table 12.3 shows that a greater proportion of the wives of manual workers than of other women had had a pregnancy which they regretted at the time, and Table 12.4 illustrates the same kind of difference between the high risk groups and other women.

12.3 Are the differences between groups diminishing?

There was some evidence that the situation had changed since 1970. Amongst women who had been pregnant and were still (they believed) fecund, the proportion who had regretted their last pregnancy had fallen slightly from 17 per cent to 14 per cent. There had, however, been no change for the non-manual groups, nor for the low risk woman and it was the wives of manual workers and the high risk groups who had apparently become rather less prone to unwelcome pregnancy.

Table 12.1 Number of informants' living children (family size) by social class

Number of living children	All classes	Social class				
		Non-manual	Manual			Total
			III	IV & V		
	%	%	%	%	%	
0	20	24	18	16	18	
1	23	22	24	21	23	
2	34	36	33	33	33	
3	14	14	16	14	15	
More than 3	8	4	9	16	11	
Base: ever-married women under 41 = 100%						
	2,304	903	1,023	418	1,441	

Table 12.2 Number of informants' living children (family size) by risk group

Number of living children	Risk groups			
	Class IV or V	Married before aged 20	Conceived before marriage	None of these things
	%	%	%	%
0	16	12	4	26
1	21	20	14	25
2	33	34	40	34
3	14	19	22	11
More than 3	16	14	20	4
<i>Base: ever-married women under 41 = 100%</i>				
	418	803	406	1,188

Table 12.3 Reactions to last pregnancy by social class

Reaction to last pregnancy	All classes	Social class			
		Non-manual	Manual		
			III	IV & V	Total
	%	%	%	%	%
Pleased	57	60	55	53	55
Wished earlier	4	3	4	4	4
Wished later	5	4	6	7	6
Sorry it happened at all	15	11	18	18	18
Other	3	2	4	4	4
No pregnancy	16	19	14	12	13
<i>Base: ever-married women under 41 = 100%</i>					
	2,344	903	1,023	418	1,441

Table 12.4 Reactions to last pregnancy by risk group

Reaction to last pregnancy	Risk groups			
	Class IV or V*	Married before aged 20*	Conceived before marriage*	None of these things
	%	%	%	%
Pleased	53	57	56	58
Wished earlier	4	5	2	3
Wished later	7	6	7	4
Sorry it happened at all	18	19	29	10
Other	4	3	6	2
No pregnancy	12	9	0	22
<i>Base: ever-married women under 41 = 100%</i>				
	418	803	406	1,188

*These groups are not mutually exclusive.

For example the proportion of Class IV or V women who had regretted their last pregnancy had fallen from 24 per cent to 17 per cent between 1970 and 1975 (Tables 12.5 and 12.6).

It seems true that the wives of manual workers and women in the high risk groups remained more prone to unwanted pregnancy than other women, but that the difference was diminishing.

For the sake of simplicity we concentrate on regretted pregnancies, but it is equally interesting that the proportion of pregnancies reported as mis-timed (too early or too late) had also decreased between 1970 and 1975, whilst the proportion positively welcomed had grown considerably in every social class.

12.4 The way the gap between the social classes had been narrowing

(a) **Pregnancy rates** In theory, the change described above could occur when the fertility and pregnancy rates for the manual or high risk groups were rising if at the same time the women concerned were wanting more or more closely spaced children than previously. It is possible to consider this question here only in relation to social class, since the numbers in the high risk groups are too small for detailed analysis.

The fall in fertility rates in general has already been described (Chapter 1) and it has been shown from population figures that the decline, at least between 1970 and 1975, occurred in every social

Table 12.5 Reactions to last pregnancy, according to social class—1970 and 1975

Reactions to last pregnancy	All classes		Social class and year of survey							
			Non-manual				Manual			
	1970	1975	1970	1975	1970	1975	1970	1975	Total	
	%	%	%	%	%	%	%	%	%	%
Pleased	58	70	63	77	56	68	52	62	55	67
Wished earlier	11	4	12	4	12	5	9	6	11	5
Wished later	11	7	10	6	10	7	12	10	11	8
Sorry it happened	17	14	11	12	19	16	24	17	21	16
Other	2	3	3	2	2	3	3	4	2	3

Base: ever-married, ever pregnant fecund women under 41* = 100%

1,981 1,610 672 615 891 714 390 281 1,281 995

*Note that the base excludes never-pregnant women and therefore that the 1975 figures differ from those in tables 12.3 and 12.4.

Table 12.6 Reactions to last pregnancy, according to risk groups—1970 and 1975

Reactions to last pregnancy	Risk groups and year of survey							
	Class IV & V		Married before 20 years		Conceived before marriage		None of these things	
	1970	1975	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%	%	%
Pleased	52	62	50	66	49	60	64	77
Wished earlier	9	6	10	5	6	2	14	4
Wished later	12	10	14	8	15	9	8	5
Sorry it happened	24	17	24	17	28	24	10	11
Other	3	4	2	3	2	5	2	2

Base: ever-married, ever pregnant fecund women under 41* = 100%

390 281 624 571 432 300 919 795

*Note that the base excludes never-pregnant women and therefore that the 1975 figures differ from those in tables 12.3 and 12.4.

class. The fertility rate of the manual group, however remained higher than that of the non-manual groups in 1975.² There was some indication of a reduction in the difference between the classes but it was unclear whether this signified a genuine convergence, or a difference between the classes in the phasing of family formation.

The pregnancy rates of the survey women, like the fertility of the population, also generally showed a decline over the 1960s and early 1970s for both the main social classes and a higher rate for the manual than non-manual groups (Table 12.7). For example, three years after the start of 3rd intervals beginning in 1956–60, 44 per cent of the non-manual and 53 per cent of the manual groups had had a 3rd pregnancy; whilst equivalent figures for 3rd intervals beginning in 1971–75 were 31 per cent (non-manual) and 34 per cent (manual).

The only exception both to the decline in pregnancy rates and the superiority of the rates for the manual group occurred for 2nd intervals. In this case rates for both classes increased from the early

1950s and only declined in 1971–75, and in addition, rates for the non-manual were higher than for the manual group until the early 1970s.

In summary, the difference between the social classes is this:—

The wives of manual workers got pregnant more quickly after marriage than other women.³ But once a first pregnancy had occurred it was the non-manual groups who (until 1971–75) followed it most rapidly by a second. Thereafter, however, the manual women were the most likely to go on to have a third and then a fourth pregnancy.

The percentages by which the manual exceeded the non-manual rates are also shown in Table 12.7. For 1st intervals there is little change in the difference until 1971–75 when it widened because the rate for the non-manual groups plummeted.

For 2nd intervals, as already noted, the rate for the manual groups was generally lower than that for other women until 1971–75 when the position

²D Pearce and M Britton—the decline in births: some socio-economic aspects. *Population Trends* 7, Spring 1977.

³The statement here refers only to those not pregnant at marriage.

Table 12.7 Pregnancy rates per 100 women—manual and non-manual groups compared according to order of inter-pregnancy interval and 5-year period in which interval began

Number of months after beginning of interval	Year in which interval began and social class group									
	1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
1st Interval										
12	38	46	42	51	39	46	34	40	21	33
24	55	59	60	69	55	65	49	59	33	50
36	68	70	70	76	68	72	66	69	47	61
Excess of manual over non-manual rates	2		6*		4*		3*		14*	
2nd Interval										
12	16	24	22	50	28	28	29	33	20	26
24	41	47	51	52	61	55	59	58	49	50
36	57	65	68	66	78	72	77	74	59	65
Excess of manual over non-manual rates	8*		-2		-6		-3		6	
3rd Interval										
12	17	20	13	18	20	23	18	17	21	17
24	39	33	35	42	34	41	28	32	25	28
36	47	44	44	53	44	51	35	41	31	34
Excess of manual over non-manual rates	-3		9*		7		6		3	
4th Interval										
12			9	21	18	25	13	19	11	17
24			22	40	27	39	18	29	24	30
36			29	53	36	46	20	35	25	32
Excess of manual over non-manual rates			24**		10*		15**		7	

*Significant at the 5% level.

**Significant at the 1% level.
(See Annex 1 to this chapter)

was reversed, again because the rate for non-manual wives fell the most steeply.

By contrast, for 3rd and 4th intervals there is a suggestion that the gap between the social classes was narrowing.

(b) **Planned pregnancy rates** Planned pregnancy rates (amongst those who used contraception—see Chapter 9) present a very different picture (Table 12.8). Unlike total pregnancy rates, they were nearly always lower for the manual than for the non-manual group. This means that amongst couples who used contraception successfully the manual groups were aiming to have fewer or more widely spaced pregnancies than other successful users.

But in 1971-75 the position for 1st and 2nd pregnancies changed as the planned rates for the non-manual women fell more steeply than those for the manual group, ie the non-manual women were aiming to defer or limit 1st and 2nd pregnancies more severely than other women.

(c) **The difference between planned and total pregnancy rates** Because total pregnancy rates had

been higher for the manual than non-manual group (except for 2nd intervals) but planned rates lower, the gap between planned and total rates was necessarily greater for the manual wives (Table 12.9). For both social classes the gap between planned and total rates was diminishing but more markedly for the manual than non-manual group. The 'unplanned' pregnancy rate was therefore falling most rapidly for the wives of manual workers.

The 'unplanned' pregnancy rates in Table 12.9 are derived on the assumption that the planned rates of those using contraception successfully represent the way all couples would have liked to space and limit their pregnancies, but as noted in Chapter 9, it cannot be assumed that all who did not use contraception had the same intentions as those who did: at least some of the women who used none must have wanted (planned) to conceive as soon as possible after marriage or their last pregnancy. Nevertheless, the earlier evidence that the incidence of regretted pregnancies was declining and especially amongst the wives of manual workers (see Table 12.5) suggests that the gradual convergence of total and planned pregnancy rates—as defined here—signifies the increasing

Table 12.8 Planned pregnancy rates per 100 women at risk—manual and non-manual groups compared, according to order of inter-pregnancy interval* and 5-year period in which interval began

At month after beginning of interval	Year in which interval began and social class group									
	1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
1st Interval										
12	14	16	19	23	18	17	19	17	13	17
24	35	33	38	41	34	38	35	37	24	33
36	51	47	53	52	51	49	55	51	36	48
Excess of manual over non-manual rates	-4		-1		-2		-4		12*	
2nd Interval										
12	7	4	10	7	14	8	9	9	9	13
24	22	20	33	23	44	32	39	29	35	37
36	43	39	53	37	67	56	57	48	44	52
Excess of manual over non-manual rates	-4		-16**		-11**		-9*		8	
3rd Interval										
12			6	3	8	3	7	3	10	5
24			20	14	18	12	11	11	15	11
36			25	19	25	14	17	15	18	16
Excess of manual over non-manual rates			-6		-11*		-2		-2	

*Significant at the 5% level.

**Significant at the 1% level.

(See Annex 1 to this chapter)

Note: rates for the 4th Interval are not given because of the small base numbers.

Table 12.9 Difference between total and planned pregnancy rates at 36 months following beginning of interval—manual and non-manual groups compared, according to order of inter-pregnancy intervals* and 5-year period in which interval began

	Year in which interval began and social class group									
	1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
1st Interval										
Total rate	68	70	70	76	68	72	66	69	47	61
Planned rate	51	47	53	52	51	49	55	51	36	48
'Unplanned' rate (= difference between planned and total rates)	17	23	17	24	17	23	11	18	11	13
Excess of manual over non-manual rates	6		7		6		7		2	
2nd Interval										
Total rate	57	65	68	66	78	72	77	74	59	65
Planned rate	43	39	53	37	67	56	57	48	44	52
'Unplanned' rate (= difference between planned and total rates)	14	36	15	29	11	26	20	26	15	13
Excess of manual over non-manual rates	22		14		15		6		-2	
3rd Interval										
Total rate			44	53	44	51	35	41	31	34
Planned rate			25	19	25	14	17	15	18	16
'Unplanned' rate (= difference between planned and total rates)			19	34	19	37	18	26	13	18
Excess of manual over non-manual rates			15		18		8		5	

*Rates and differences cannot be given for 4th Intervals because of the smallness of the base numbers for planned pregnancy rates.

Table 12.10 Use of contraception during each inter-pregnancy interval—manual and non-manual groups compared, according to order of inter-pregnancy interval and 5-year period in which interval began

	Year in which interval began and social class group									
	1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
1st Interval	%	%	%	%	%	%	%	%	%	%
Used contraception	60	43	64	45	71	53	81	64	92	76
Percentage by which manual fell short of non-manual use	17		19		18		17		16	
2nd Interval										
Used contraception	69	56	74	55	80	65	79	72	86	75
Percentage by which manual fell short of non-manual use	13		19		15		7		11	
3rd Interval										
Used contraception	79	61	77	62	83	68	86	79	84	82
Percentage by which manual fell short of non-manual use	18		15		15		7		2	
4th Interval										
Used contraception	74	60	76	62	77	63	83	74	83	82
Percentage by which manual fell short of non-manual use	14		14		14		9		1	

ability of women, particularly the manual group, to limit their pregnancies in the way they wish.

12.5 Some components of the change in class differences

(a) Contraceptive use Information about contraceptive use is available for the first 4 inter-pregnancy intervals and shows in every case an increase over time for both social classes but that use had always been lower in the manual than non-manual group (Table 12.10).

The figures again show a reduction in the difference between the classes; slight and uncertain for the 1st and 2nd intervals, but clear and considerable for 3rd and 4th intervals, for which the convergence occurred in the late 1960s and early 1970s. This was partly because use by the non-manual groups did not increase in 1971-75.

The timing of the convergence suggests that developments in the family planning services may have been responsible (see Chapter 1).

Table 12.11 Use of service-specific contraceptive methods during each inter-pregnancy interval, manual and non-manual groups compared, according to order of interval and 5-year period in which interval began

Contraceptive method	Year in which interval began and social class											
	1946-50		1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%	%	%
1st Interval												
Pill	0	0	0	0	2	1	12	8	48	27	72	60
IUD	0	0	1	0	..	0	1	0	2	2	5	2
Cap	8	2	15	3	16	6	17	5	14	6	6	2
2nd Interval												
Pill	1	0	1	1	2	3	13	12	35	31	47	42
IUD	0	0	0	0	1	..	0	0	4	3	8	8
Cap	11	3	15	5	16	8	17	4	13	3	7	3
3rd Interval												
Pill			5	2	5	5	18	18	37	38	48	47
IUD			0	0	1	0	4	3	8	7	5	11
Cap			16	8	19	6	14	7	9	4	7	1
4th Interval												
Pill			6	2	7	6	22	20	38	39	34	40
IUD			6	0	2	2	5	4	10	8	10	10
Cap			24	11	20	5	21	7	11	4	9	0

Table 12.12 Contraceptive failure rates per 100 users at 12 months all methods combined. Manual and non-manual groups compared according to order of inter-pregnancy interval* and 5-year period in which interval began

	Year in which interval began and social class group									
	1951-55		1956-60		1961-65		1966-70		1971-75	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
1st Interval	18	19	15	15	15	13	8	14	5	9
Excess of manual over non-manual rate	1		0		-2		6		4	
2nd Interval	8	13	10	13	11	14	11	15	7	6
Excess of manual over non-manual rate	5		3		3		4		-1	
3rd Interval			2	12	10	14	6	8	3	6
Excess of manual over non-manual rate			10		4		2		3	

*Rates for 4th Interval cannot be given because of the smallness of the base numbers.

But there was no evidence from trends in the use of service specific methods (pill, IUD, cap) that this was true. Table 12.11 shows that in 3rd and 4th intervals, use of the pill and IUD had grown at more or less the same rate in both social classes, and there was no particular spurt in their use by the manual groups in 1966-70.

Use of the cap which had been most popular amongst the non-manual group was declining for both classes.

(b) **Contraceptive failure rates** Failure rates for both social classes were declining (Table 12.12). Those for the manual group were generally slightly higher than for the non-manual group and there was no evidence that the difference was diminishing.

It is, however, the smallness of the differences between the classes which must be stressed. The wives of manual workers who practised contraception were, it seems, almost as successful as other wives in limiting their pregnancies even

though for much of the period covered they had been aiming to restrict their pregnancies more severely than the non-manual groups (see Table 12.8).

(c) **Sterilisation** Sterilisation may also have played some part in the reduction of social class and other inter-group differences in excess fertility.

Table 12.13 shows that a slightly greater proportion of the wives of manual than of non-manual workers had been sterilised (12 per cent compared with 9 per cent) and Table 12.14 shows the same kind of difference between the high and low risk groups: for example 15 per cent of the women who had married before they were 20 had been sterilised, but only 8 per cent of the low risk women.

It was shown in the last chapter that the more children a woman had the more likely she (or her husband) was to have been sterilised and it was seen earlier in this one, that the manual and high risk groups tended to have more children than

Table 12.13 Percentages of women who (or whose husbands) had been sterilised according to social class

	All classes	Social class			
		Non-manual	Manual		
			III	IV & V	Total
	%	%	%	%	%
Not sterilised	84	85	85	83	83
Sterilised	11	9	12	12	12
Other operation	6	6	6	5	5
Total operations	16	15	17	17	17
Base: ever-married women 16-55 = 100%					
	3,898	1,516	1,651	730	2,381

Table 12.14 Percentages of women who (or whose husbands) had been sterilised according to risk group

	Risk groups			
	Class IV or V	Married before 20 years	Conceived before marriage	None of these things
	%	%	%	%
Not sterilised	83	79	76	86
Sterilised	12	15	17	8
Other operation	5	5	6	6
Total operations	17	21	24	14
<i>Base: ever-married women 16-55 = 100%</i>				
	730	1,083	556	2,156

others. The greater prevalence of sterilised couples in these groups could therefore have been due to the sterilisation of those with larger than average families.

This appeared to be true for class IV and V, but, amongst those with more than one child, the women who had married before the age of 20 and those who had conceived before marriage were more likely than others to belong to a sterilised couple regardless of their family size (Table 12.15). Thus for these women sterilisation may have helped to reduce their tendency to excess fertility by being carried out before rather than after an unwanted pregnancy had occurred.

Summary and discussion

In 1975, as in 1970, some groups of women were more likely than others to have more than three children and, most relevant here, to have regretted their last pregnancy. The groups concerned were the wives of manual workers, but especially those in classes IV and V, women who married before they were 20, and those who had conceived before marriage.

It therefore appears to be still important that the family planning services should be particularly accessible and attractive to these women.

There was some indication that service use was latterly growing more rapidly amongst the manual than non-manual group (see Chapter 2) and the complete removal of charges in mid-1975 may have accentuated this trend after the survey was carried out.

Even by 1975, at the time of the survey, there was evidence that the excessive vulnerability of the manual and high risk groups to unwanted pregnancy had diminished since 1970. In the case of the narrowing of the social class difference it was possible to trace the way this might have come about through the pregnancy histories. These showed that whilst the total pregnancy rates of the manual group were always higher than those for other women, the planned rates amongst contraceptive users in the group were for the most part lower. The gap between planned and actual pregnancies was therefore greatest for the manual group, and although it remained so in 1970-75 it was closing more rapidly in their case than for the wives of non-manual workers. This was most noticeable for the 3rd of the first three pregnancies.

Table 12.15 Percentages of women who (or whose husbands) had been sterilised according to risk group and number of children

	Risk group			
	Class IV & V	Married before 20 years	Conceived before marriage	None of these things
	%	%	%	%
a. 1 living child				
Sterilised	3	2	0	3
Base:	145	94	66	508
b. 2 living children				
Sterilised	10	10	12	10
Base:	227	363	198	734
c. 3 living children				
Sterilised	21	26	18	14
Base:	122	222	128	306
d. 4 living children				
Sterilised	18	27	24	23
Base:	72	100	67	92
e. 5 or more living children				
Sterilised	26	35	45	29
Base:	69	93	75	63

The change appeared to have been mainly due to the particularly steep increase in contraceptive use by the manual group rather than to a disproportionate fall in their contraceptive failure rates. Again the evidence was clearest for the interval after the second pregnancy and before a third (if it occurred) and happened in the late 1960s and early 1970s.

Nevertheless the general fall in contraceptive failure rates may have been particularly beneficial to the manual group since, in 1970, they were especially inclined to regret a pregnancy which occurred whilst contraception was being used.⁴

⁴M Bone. *Op cit.* p 48, Table 6.11.

Annex Probabilities of the differences between pregnancy rates of the non-manual and manual groups occurring by chance.

Note Significance tests were applied only to the figures on which Tables 12.7 and 12.8 were based. Gehan's generalised Wilcoxon test was used (see Annex 1 to Chapter 9)

1. Probabilities of the differences between total pregnancy rates of the non-manual and manual groups being due to chance

Interval order	Year in which interval began				
	1951-55	1956-60	1961-65	1966-70	1971-75
1	0.065	0.006	0.011	0.016	0.001
2	0.035	0.324	0.115	0.495	0.143
3	0.299	0.023	0.071	0.136	0.340
4		0.000	0.034	0.010	0.195

The probabilities listed above show that the differences between the non-manual and manual rates for first (post-marital) pregnancies and for fourth pregnancies (up to the end of the 1970s) are unlikely to be due to chance. On the other hand the differences between the two social class groups for second and third pregnancy rates are not statistically significant.

In addition the increase in sterilisations may have helped to reduce the difference in excess pregnancies, perhaps less between the social classes than between high risk and other women. The reason for thinking this is happening is that women who married before 20, or conceived before marriage were more likely than others to have been sterilised even if they had only two or three children.

Finally, it must be stressed that the differences between groups had not disappeared in 1975, and only later evidence will reveal whether they continue to diminish.

2. Probabilities of differences between planned pregnancy rates for the manual and non-manual groups being due to chance

Interval order	Year in which interval began				
	1951-55	1956-60	1961-65	1966-70	1971-75
1	0.281	0.266	0.480	0.427	0.021
2	0.212	0.002	0.001	0.027	0.213
3		0.098	0.023	0.158	0.133

Only the second planned pregnancy rates were consistently significantly lower for the manual than for the non-manual group (between the late 1950s and late 1960s). But the excess of the manual over the non-manual 1st interval rate in 1971-75 is also unlikely to be due to chance.

Some of the differences between the social class groups described in the text are therefore not supported by the statistical tests (although they are not thereby disproved). In particular for third pregnancy rates, since the differences between the social class groups are not firmly established their diminution must also remain open to question.

13 Single women—introduction

13.1 The background

From 1968 the (then) local health authorities were enabled to provide contraceptive advice to all who wanted it regardless of marital status,¹ and because the 1970 survey was concerned with the effectiveness of the family planning services as a whole, single women were included in its scope. At that time few single women in the age range covered (16–35) had ever used the services (10 per cent had done so) but many more (24 per cent) had used, or their partners had used, contraception.

Since 1970 there have been declines for women under 25 in numbers and rates of illegitimate live births, abortions amongst the unmarried (since 1974), and of pre-maritally conceived live births to married women.² These are aspects of an overall decline in the known extra-marital conception rates from 36.7 per thousand unmarried women aged 11–24, to 30.8 per thousand between 1970 and 1975.³

It is highly unlikely that the level of sexual activity amongst the unmarried fell during the period 1970–75 and the most obvious explanation for the reduction in conception rates is that contraception was increasingly widely and effectively practised by those who were sexually active.

This part of the report is concerned firstly with changes in the use of family planning services and contraception which may help to account for the decline in conception rates, and secondly—because there is scope for their further reduction—with the ways in which the services as distributors of the most effective reversible method (the pill) might become easier for the unmarried to use.

To do both, it is useful to begin by considering the proportion of single women at risk, those liable to have intercourse before marriage, and the way this changed between 1970 and 1975, and this is the subject of sections 13.3 to 13.4.

¹Family Planning Act 1967.

²J Thompson—Fertility and abortion inside and outside marriage. *Population Trends*, 5, Autumn 1976, HMSO.

³R H Edmunds and A Yarrow—Newer fashions in illegitimacy—*British Medical Journal* 1977, 1, 701–703. Available figures are of extra-marital conceptions, but under the age of 25, pre-marital conceptions are likely to comprise the great majority of such conceptions.

13.2 The age range included

It was noted in Chapter 1, that the 1970 survey covered single women aged 16–35, but that in 1975 the age range was extended upwards to include women aged 36–40. The age limit was raised, as in the case of married women, both to cover the entire range of potential service users and so that any special problems of older women in using contraception or the services could be examined. However, less than 10 per cent of females are unmarried by the time they are in their late 40s,⁴ and, as foreseen, the raising of the age limit added few extra single women to the sample: only 29 out of 749 interviewed were aged 35–40. Even if all those aged 30 or more are grouped together, the resulting 50 women are too few for detailed analysis.

For this reason no attempt is made to consider any special problems of older single women. Where comparisons are made between 1970 and 1975, the women covered will be limited to those under 36 in each year. Where the situation in 1975 is the main concern, all the women in the 1975 sample—up to and including age 40—will be covered.

13.3 Single women at risk

When looking at the use of services and contraception by single women it would be useful to focus on a group comparable to the married women 'at risk': women who were fecund, neither pregnant nor attempting to conceive and who were exposed to intercourse.⁵

One of the important questions about the period 1970–75 is how the proportion of single women at risk in this sense had changed, but, as noted in Chapter 1, it was not considered appropriate in either year to ask single women about their sexual experience. The numbers and kinds of women exposed to intercourse are therefore unknown and in addition no systematic information on sterility was collected because it seemed probable that single women would not know whether they were

⁴R Leete—Marriage and divorce—*Population Trends* 3, Spring 1976, HMSO.

⁵Exposure to intercourse was assumed in the case of married women, but the examples of older women not using contraception described in Chapter 6 show that the assumption is not always correct.

fecund.⁶ For these reasons it is impossible to construct a group of single women at risk of conception, although it is assumed that almost all conceptions occurring to single women are unintended.⁷

There is, however, a wider group amongst the unmarried who may be considered at risk of intercourse rather than directly of conception. This is composed of the women who have not decided against having intercourse before marriage, whether or not they are already experienced. These women are presumably more likely than others to enter into a sexual relationship even if they currently have none and it is therefore particularly important that they should have clear ideas about contraception and no disquiet about using the services.

There were a number of questions during the course of the interview which were expected to elicit a statement that the informant would not have intercourse before marriage if this was the case, the first of which was about the contraceptive method she anticipated using whilst single.⁸

The women who made no statement of this kind can be considered to have a propensity to pre-marital intercourse. The proportions involved in 1970 and 1975 can be compared to show changes in the acceptability of pre-marital intercourse, whilst their knowledge and views of the services and actual or anticipated use of contraception are especially relevant to the purposes of the survey.

Some of the women, particularly if they are young, who say they will not have intercourse before marriage will later change their minds and will then need to be well informed and rational about contraception and the services. However, because of their position at the time of the survey, they were not asked for their views on using the services whilst unmarried nor some of the questions on contraception. In addition to the difficulty of obtaining realistic answers to such

questions from this group, it was assumed that the chances of their becoming sexually active were at least less immediate than those of the women who did not reject the idea of pre-marital intercourse.

13.4 The propensity to pre-marital intercourse

In both 1970 and 1975 only a minority of women under 36 when interviewed said they would not have intercourse before marriage. But, whilst over a third (36 per cent) rejected the idea in 1970, only a quarter did so in 1975. In this sense the proportion of single women at risk of intercourse and who were therefore potential service users had increased.

(a) **The relationship with age** In 1975, the proportions of women not rejecting pre-marital intercourse increased with age up to the early 20s and then declined, so that 68 per cent of 16-17 year olds were at risk, 82 per cent of 20-24 year olds and 66 per cent of those aged 30 or more. The reduction after the early 20s may be partly due to generational changes and partly to the kind of women who remain unmarried after the age of 24⁹ (Table 13.1).

The same relationship, between being at risk of intercourse and age was evident in 1970, but it is of some interest that although the proportion at risk had increased in every age group, the greatest increase was amongst those aged 20 or more. For example, whilst the proportion of 16-17 year olds at risk had risen from 61 per cent to 68 per cent, the rise for 20-24 year olds was from 68 per cent to 82 per cent (Table 13.2).

(b) **The relationship with social class** In both 1970 and 1975 there were only small differences between the social classes in the proportions at risk of pre-marital intercourse. The absence of difference was evident for the samples as a whole, but it seemed from the 1975 material that the different age composition of the two main social classes concealed differences in their risk states. Daughters of manual workers marry earlier on average than

⁶Only 2 single women said they had been sterilised.

⁷Single women were not asked for their views on getting pregnant before marriage, but only 1 per cent said they would not marry but might have children.

⁸Question 10(b).

⁹Well over half the women aged 20-24 in each year were married throughout the 1960s and early 1970s, and the average age at marriage in 1974 was 22.7 years—R. Lette—Marriage and Divorce, *Population Trends* 3, Spring 1976.

Table 13.1 Percentages of single women who said they would not have intercourse before marriage, by age—1975

	All ages	Age at interview					
		16/17	18/19	All under 20	20-24	25-29	30-41
	%	%	%	%	%	%	%
Rejects pre-marital intercourse	25	32	27	30	16	24	32
Does not reject	74	68	73	70	82	75	66
Not known	1	0	0	0	2	1	2
Base: single women 16-40 = 100%	749	216	180	396	228	75	50

Table 13.2 The proportion of single women who said they would not have intercourse before marriage, by age—1970 and 1975

	All ages		Age at interview				
			16/17	18/19	All under 20	20-24	25-35
	%	%	%	%	%	%	%
a. 1970							
Rejects pre-marital intercourse	36	38	35	36	32	46	
Does not reject	63	61	64	62	68	52	
Not known	1	1	2	1	0	1	
<i>Base: single women 16-35 = 100%</i>	974	298	268	566	308	99	
b. 1975							
Rejects pre-marital intercourse	25	32	27	30	16	24	
Does not reject	74	68	73	70	82	75	
Not known	1	0	0	0	2	1	
<i>Base: single women 16-35 = 100%</i>	724	216	180	396	228	100	

Table 13.3 Percentages of single women who said they would not have intercourse before marriage, by age and social class—1975

	Age and social class									
	16-17		18-19		All under 20		20-24		25-41	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
Rejects pre-marital intercourse	41	28	25	29	34	28	15	17	33	20
Does not reject	59	72	75	71	66	72	83	81	65	79
Not known	0	0	0	0	0	0	3	2	2	2
<i>Base: single women 16-40 = 100%</i>	66	148	59	119	125	267	109	113	57	61

other girls,¹⁰ and for this reason those who are still single tend to be younger than the daughters of non-manual workers. Thus 60 per cent of the manual group interviewed in 1975 were under 20, compared with 43 per cent of the non-manual women. Within age groups the numbers in each social class are small, but it appears that amongst girls of 16 to 17 and women aged 25-41 greater proportions of the manual than of the non-manual groups were at risk (Table 13.3).

(c) **The association with engagement and having boyfriends** It is possible that the chances of having intercourse increase when women become engaged. If this is true it is not reflected in the proportions at risk (not rejecting intercourse). The greatest difference overall in the proportions at risk was between those who had a boyfriend or fiancé and those who had neither, and women with boyfriends were rather less likely to reject the idea of pre-marital intercourse than those who were engaged. This pattern was evident in every age group (Tables 13.4 (a)-(d)).

In 1975, 18 per cent of the 16-41 year old women were engaged and 43 per cent had boyfriends leaving 39 per cent with neither. These proportions were almost identical with those found in 1970 in the 16-36 year age range.

Table 13.4 Percentages of single women who said they would not have intercourse before marriage, by current attachment

	Engaged	Has boyfriend	Neither
	%	%	%
(a) All women			
Rejects pre-marital intercourse	25	18	33
Does not reject	72	82	66
Not known	3	0	1
<i>Base: single women 16-40 = 100%</i>	135	325	289
(b) Aged 16-19			
Rejects pre-marital intercourse	32	22	38
Does not reject	68	78	62
<i>Base: single women 16-19 = 100%</i>	60	176	160
(c) Aged 20-24			
Rejects pre-marital intercourse	18	14	17
Does not reject	77	86	80
Not known	5	0	3
<i>Base: single women 20-24 = 100%</i>	60	97	71
(d) Aged 25-40			
Rejects pre-marital intercourse	18		38
Does not reject	81		60
Not known	1		2
<i>Base: single women 25-40 = 100%</i>	67		58

¹⁰Office of Population Censuses & Surveys—unpublished data.

As was to be expected, the proportions engaged increased until the early 20s and then declined. Although the proportions having boyfriends did not fall until the early 30s, those having neither fiancés nor boyfriends rose from the late 20s onwards (Table 13.5).

The daughters of manual workers were engaged earlier than other girls, but were no more likely than others to have boyfriends before they were 20. However, because a larger proportion of the teenage manual group were engaged, more of them had an attachment of one kind or the other (Table 13.6). This is a further indication that the manual group are, on the whole, likely to need effective contraception at an earlier age than others.

13.5 Locating single women at risk

Under the age of 25 the rates of extra-marital

conception are highest for the age groups 20-24, but the numbers have recently been greater for those under 20.¹¹ Moreover public concern is rightly focused on pregnancies amongst young unmarried girls, and a question of practical importance is where the girls liable to have intercourse are likely to be found, and in particular whether they can be reached through schools and colleges. In 1975, they could not: three quarters of the girls under 20, and two thirds of those aged 16-17 who did not reject the idea of pre-marital intercourse had already left school, and the proportions at risk in each of the two age groups under 20 were considerably higher amongst the employed than amongst those still in full-time education (Table 13.7).

¹¹R H Edmunds and A Yarrow—*Op cit*: give rates for 1975 as: 16-19 year olds—50.4/000; 20-24 year olds—74.1/000. The numbers of extra-marital conceptions in each case were 62.9 thousand and 52.6 thousand respectively.

Table 13.5 Percentages of single women engaged or having boyfriends, by age—1975

	All ages	Age at interview					
		16/17	18/19	All under 20	20-24	25-29	30-40
	%	%	%	%	%	%	%
Engaged	18	8	24	15	26	11	14
Boyfriend	43	48	41	44	42	53	24
Neither	39	44	36	40	31	36	62
Base: single women 16-40 = 100%	749	216	180	396	228	75	50

Table 13.6 Percentages of single women engaged or having boyfriends, by age and social class—1975

	Age and social class									
	16/17		18/19		All under 20		20-24		25-40	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
Engaged	2	11	19	26	10	18	22	30	12	12
Boyfriend	48	48	37	42	43	45	50	37	47	34
Neither	50	41	44	32	47	37	28	33	40	54
Base: single women 16-40 = 100%	66	148	59	119	125	267	108	113	57	61

Table 13.7 Percentages of single women who said they would not have intercourse before marriage by age and according to whether they were employed or in full time education

	Age and educational/employment status*					
	16/17		18/19		All under 20	
	Full time education	Working	Full time education	Working	Full time education	Working
	%	%	%	%	%	%
Rejects pre-marital intercourse	44	25	38	25	42	25
Does not reject	56	75	62	75	58	75
Base: single women 16-19 = 100%	79	117	32	137	111	254

*The women who were neither in full-time education nor working full or part time are excluded from the table. 8% of the sample were involved.

The relationship appeared to hold for each social class, but the numbers on which this conclusion is based are small.

It is sometimes suggested that girls likely to be sexually active who have left school can be contacted through youth clubs. No question was asked in the survey about attachment to such groups, but an enquiry carried out at the end of the 1960s showed that at that time only a minority of the girls who left school at the minimum age (then 15, now 16) went to youth clubs or clubs of any kind once they had left school.¹² If this is still the situation, it seems that the only way to broadcast the importance of effective contraception and the role of the family planning services to the young women most at risk of having intercourse is through the media.

13.6 Discussion

Two types of risk amongst the unmarried have been described in this chapter; the first was the risk of unintended conception and the second, of exposure to intercourse.

¹²M Bone and E Ross—*the Youth Service and similar provision for young people*, London, HMSO, 1972, pp 26–27.

The first, had the necessary information been available, would have been useful in deciding how effectively the services were providing for the unmarried and the extent of non-use of reliable contraception amongst the sexually active.

The second kind of risk is relevant when considering how easy the family planning services are for the unmarried to use, since they must be acceptable and accessible not only to the women who have a current sexual relationship but also to those who may become sexually active tomorrow. The assumptions on which the value of the risk characteristic and the analyses in this chapter depend are that the girls who did not reject premarital intercourse were in fact more likely than others to be or become sexually active and that the relationships between the 'propensity' to intercourse and age and social characteristics provide some indication of those between actual sexual experience and the same characteristics. Preliminary findings from a subsequent survey concerned with fertility suggest that the assumptions are correct, although of course the proportions at risk exceed the proportions sexually experienced.¹³

¹³K Dunnell—*Family Formation Survey*—awaiting publication.

14 Single women's use and views of the family planning services

14.1 Changes in service use 1970-75

The increase in service use by single women between the two surveys was considerable: in 1970 6 per cent were currently using the services compared with 24 per cent in 1975, and whereas in 1970, 10 per cent had ever used the services, in 1975, a third had done so (Table 14.1). Service use amongst single women in 1975 was, in fact, as widespread as amongst the married women interviewed in 1970.

Table 14.1 Percentages of single women using the family planning services, 1970 and 1975 compared

Use of services	1970	1975
	%	%
Current GP user	4	13
Current FPC user	2	10
Other doctor user	..	1
Other user	NA	..
All current users	6	24
Past users	4	9
Total ever-users	10	33
Never users	88	63
Not known	1	4
<i>Base: single women</i>		
<i>16-36 = 100%</i>		
	974	724

(a) *Use of the services and age* In 1975, as in 1970, experience of the services rose with age until the early 20s and thereafter declined, so that for example, in 1975 19 per cent of 16 to 17 year olds had ever used the services, almost half the 20-24 year olds, and just over a quarter of the women

¹Definitions of current, past and never use are given in Chapter 2, p 6.

aged 30-40 (Table 14.2). Over half the current users (59 per cent) were aged 20 or more.

Single women in every age group in 1975 made more use of the services than those in the same age groups in 1970 had done (Table 14.3).

(b) *Use of the services and social class* In 1970, the daughters of non-manual workers were rather more likely than others to have used the family planning services, and although more women in every social class were using the services in 1975 (Table 14.4(a) and (b)) the difference between the classes persisted so that 30 per cent of the non-manual compared with 20 per cent of the manual group were service users. (The inclusion of women aged 36-40 would make no difference to the percentages shown in Table 14.4(a).)

It was seen in the last chapter that amongst the single women the daughters of manual workers were on average younger than others and Table 14.2 showed that girls under 20 made less use of the services than older women. However, the different age composition of the two classes did not account for the difference in service use, because in every age group but one (16/17 year olds) a greater proportion of the non-manual than of the manual groups were service users (Table 14.5).

The evidence that the difference between the social classes was least for the girls under 20 might suggest a future narrowing of the gap between the classes, were it not that the same pattern was evident in 1970 and as it turned out signalled no

Table 14.2 Percentages of single women using the family planning services, according to age—1975

Use of services 1975	Age at interview						
	All ages	16-17	18-19	All under 20	20-24	25-29	30-40
	%	%	%	%	%	%	%
Current GP users	13	7	16	11	17	12	12
Current FPC users	10	6	7	7	16	12	0
Other doctor user	1	..	1	..	2	3	0
Other user	..	1	1	1	0	0	0
All current users	24	15	24	19	35	27	12
Past users	9	4	8	6	13	12	14
Total ever users	33	19	32	24	47	39	26
Never users	63	81	66	74	46	57	70
Not known	4	1	2	2	7	4	4
<i>Base: single women</i>							
<i>16-40 = 100%</i>							
	749	216	180	396	228	75	50

Table 14.3 Percentages of single women using the family planning services according to age—1970 and 1975

Use of services	Age at interview and year of interview							
	16-17		18-19		20-24		25-35	
	1970	1975	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%	%	%
Current GP users	..	7	3	16	6	17	6	11
Current FPC users	..	6	2	7	4	16	0	9
Other doctor users*	0	..	0	1	1	2	2	2
Other user*	NA	1	NA	1	NA	0	NA	0
All current users	1	15	6	24	11	35	8	22
Past users	1	4	4	8	6	13	6	13
Ever users	2	19	9	32	17	47	14	35
Never users	97	81	90	66	80	46	85	61
Not known	1	1	1	2	2	7	1	4
<i>Base: single women 16-35=100%</i>								
	298	216	268	180	308	228	99	100

*These two categories are combined in subsequent tables.

Table 14.4 Percentages of single women using the family planning services, according to social class—1970 and 1975

Use of services	Social class				
	All classes	Non-manual	Manual		Total
			III	IV & V	
	%	%	%	%	%
a. 1975					
Current GP users	13	14	12	11	11
Current clinic users	10	13	8	9	8
Other user	2	2	2	0	1
All current users	24	30	21	19	20
Past users	9	9	10	9	9
Ever users	33	39	31	28	30
Never users	63	57	66	70	67
Not known	4	4	4	2	3
<i>Base: single women 16-35=100%</i>					
	724*	279	278	150	428
b. 1970					
Current GP users	4	5	4	2	3
Current FPC users	2	3	2	2	2
Other user	..	1	..	..	..
All current users	6	8	5	4	5
Past users	4	6	3	3	3
Ever users	10	14	8	7	8
Never users	88	85	90	92	91
Not known	1	1	1	1	1
<i>Base: single women 16-35=100%</i>					
	974†	365	375	196	571

*Includes 17 women unclassified.

†Includes 38 women unclassified.

diminution of the difference. As the material in the last chapter suggested, there is no reason to think that the daughters of manual workers have less need for effective contraception than other women (see also (d) below).

(c) **Women with fiancés or boyfriends and service use** Not surprisingly, women who were engaged or who had boyfriends were more likely than others to be using the family planning services (Table 14.6) and this was true for each age group. Those who were engaged were most likely to be users,

but the great majority (nearly 70 per cent) of current users were not engaged.

One of the commonest reasons given by past users for abandoning the services was that a relationship of this kind had ended; a point discussed further at the end of the next chapter.

(d) **Use of the services and risk of pre-marital intercourse** The relationship between service use and age or social class could be due to differences between the groups in the prevalence of sexual

Table 14.5 Percentages of single women using the family planning services by age and social class—1975

Use of family planning services* 1975	Age and social class									
	16-17		18-19		All under 20		20-24		25-40	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
All current users	14	16	30	20	22	18	41	28	26	15
Past users	2	5	8	8	5	6	11	15	14	13
Ever users	15	20	39	28	26	24	52	43	40	28
Never users	85	78	59	70	73	74	39	51	56	67
Not known	0	1	2	2	1	2	8	5	4	5
Base: single women 16-40=100%	66	148	59	119	125	267	109	113	57	61

*In the interests of simplicity the specific outlet used is omitted from this and two of the following tables in this section.

Table 14.6 Percentages of single women using the services according to whether they were engaged or had boyfriends—1975

Use of services 1975	Engaged	Has boyfriend	Neither
	%	%	%
Current GP user	24	15	5
Current clinic user	14	14	3
Other user	3	2	..
All current users	41	31	8
Past user	10	9	8
Ever user	51	40	16
Never user	43	56	81
Not known	6	4	2
Base: single women 16-40=100%	135	325	289

experience (which is not known from the survey) but they were not due to differences in the proportions at risk (who did not reject pre-marital intercourse).

Table 14.7 shows that amongst the women at risk, current service use increased over the age groups until the early 20s and that the proportions who had never used the services correspondingly declined; a point which will be developed in considering in section 2 of this chapter how the services might be made more acceptable to never users when they need advice.

Table 14.8 is also confined to single women at risk and shows that within each age group the daughters of manual workers were less likely than others to be using the services. No comparable information is available for 1970.

The increased use made of the services by single women in 1975 may have been due to a rise in the prevalence of sexual relationships or to other factors extraneous to the services which were not covered by the survey. Changes in aspects of provision between 1970 and 1975 can therefore not be used to account for increased use but they may help to indicate ways in which the services might be made easier and pleasanter for the unmarried to use. The next section is concerned with whether the women who had never used the services in 1975 were likely to find them simpler to use if they wanted to do so than their counterparts in 1970, and section 3 deals with differences in the experiences of those who used them in each year.

14.2 Impediments to service use—never users

The women of interest here are those described in the last chapter as being at risk of intercourse, who may have reason to use the services in the near future even if they have none at present.

Table 14.7 Percentages of single women at risk using the services according to age—1975

Use of services* 1975	Age at interview					
	All ages	16-17	18-19	All under 20	20-24	25-40
	%	%	%	%	%	%
All current users	32	22	32	27	41	28
Past user	12	5	10	8	16	18
Ever user	44	27	42	34	57	46
Never user	52	72	55	64	36	49
Not known	4	1	3	2	7	4
Base: single women 16-40 at risk=100%	553	147	131	278	186	89

*See note to Table 14.5.

Table 14.8 Percentages of single women at risk using the services according to age and social class—1975

Use of services* 1975	Age and social class					
	Under 20		20-24		25-40	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%
All current users	31	24	49	34	38	19
Past user	7	8	13	18	22	17
Ever user	38	32	62	52	59	36
Never user	60	66	30	42	35	60
Not known	1	2	8	5	5	4
<i>Base: single women 16-40 at risk=100%</i>						
	83	192	90	92	37	48

*See note to Table 14.5.

Fifty-two per cent of the women at risk in 1975 had never used the services compared with over 80 per cent of those in the corresponding 1970 group.

In 1975, the never users at risk were young compared with those who had used the services, and in particular a much higher proportion of the first group were aged 16 to 17 and a much lower proportion were 20-24 (Table 14.9).

Table 14.9 Age distribution of single women at risk who had never used the services and of those who had—1975

Age at interview	Use of family planning services	
	Never used	Current and past users
	%	%
16/17	37	16
18/19	25	23
All under 20	62	39
20-24	23	44
25-40	15	17
<i>Base: single women 16-40 at risk of intercourse = 100%</i>		
	289	242

The different age compositions of the two groups is relevant to developments in the services, because whilst they must be acceptable, when needed, to the predominantly teenage never users at risk, they must not as a consequence deter the over 20s who comprised the majority of past and current users.

(a) **General acceptability of the services to never users** In both 1970 and 1975 only a minority of never users at risk had considered using GPs or clinics to get contraceptive advice but it seemed rather fewer of the 1975 than 1970 group had thought of using either of the main sources of advice (Table 14.10). This is possibly because women who had the idea of using the services in

Table 14.10 Percentages of single women considering and preferring each source of advice—1970 and 1975

	1970	1975
	%	%
(a) Had thought of using:		
Clinic	25	20
GP	30	23
(b) Whilst single is most likely to use:		
Clinic	54	42
GP	36	45
(c) Whilst single would prefer:		
Ordinary Clinic	17	17
Clinic for the unmarried	49	28
GP	28	35
Haven't thought/not known	6	20
<i>Base: single women 16-35 at risk who had never used the service = 100%</i>		
	519	283

the later year were more likely than the 1970 group to make up their minds and do so rather than to spend time thinking about it. Some slender support for this speculation appears for those who had considered using clinics. Over a quarter of this small group (54) women said, in 1975, that they were definitely planning to go compared with 16 per cent in 1970. For those thinking of using their GPs, there was no change in the proportion who had reached this decision; about 16 per cent in both years.

Perhaps the most interesting changes between the two years are the increased popularity of GPs and the reduced emphasis on special clinics for the unmarried.

In the first case, whereas 36 per cent of the 1970 never users at risk said they were most likely to go to their own doctor if they did decide to seek advice whilst single, 45 per cent of the 1975 group said this, and unlike in 1970, the proportion anticipating GP use was greater than of those expecting to go to a clinic. In addition, whilst 28 per cent in 1970 said they would prefer to go to

their GP, 35 per cent said this in 1975 (Table 14.10(b)).

The corresponding decline in preference for a clinic (from 66 per cent to 45 per cent) was wholly due to a reduction in the proportion opting for a clinic specifically intended for the unmarried; from nearly a half to just over a quarter. A possible explanation for the change is that single women had come to feel less need for a formal indication that their requests for contraceptive advice would be treated as a matter of course. However, an increase in the proportion for whom the preference was unknown, due to a change in the questioning procedure,² means that the apparent reduction in the percentage choosing a clinic for the unmarried could be more apparent than real.

The large proportion of unknowns is a handicap to interpretation but it appears that, in 1975, there were considerable differences in preferences between the age groups, and it was the youngest women who were most likely to want a special clinic for the unmarried; over a third of the under 20s chose this option (Table 14.11). It is relevant here that only 4 per cent of current clinic users

²In 1975, unlike in 1970, the women who had not thought which service they were most likely to use were not asked which they would prefer to use. This was due to an undetected printing error.

were attending special clinics or special sessions for the unmarried.

(b) Knowledge of the services Knowledge of sources of contraceptive advice was much more widespread in 1975 than in 1970. In the earlier year only a third of the never users at risk knew of an accessible source compared with over three-quarters in 1975, and whilst 42 per cent knew of a clinic (not necessarily local) in 1970, 60 per cent knew of one in 1975 (Table 14.12).

The youngest girls (aged 16 and 17) were least likely to know of an accessible source, but even so 70 per cent of the group were well informed (Table 14.13).

Table 14.12 Single women's knowledge of sources of contraceptive advice—1970 and 1975

	1970	1975
	%	%
(a) Knows of local source	32	76
Knows of no local source but knows of a source	30	10
Knows of no source	38	14
(b) Knows of a clinic	42	60
Knows of no clinic	58	38
No answer		2
<i>Base: single women 16-35 at risk who have never used the service = 100%</i>	519	283

Table 14.11 Percentages of single women preferring each source of advice, according to age—1975—never users at risk

Source of advice preferred	Age at interview				
	16-17	18-19	All under 20	20-24	25-35
	%	%	%	%	%
Ordinary clinic	17	15	16	21	16
Clinic for the unmarried	39	29	35	15	16
GP	32	32	32	39	45
Haven't thought or not known	12	24	17	25	24
<i>Base: single women 16-35 at risk who have never used the services = 100%</i>	106	72	178	67	38

Table 14.13 Single women's knowledge of sources of contraceptive advice according to age—1975

	Age at interview				
	16-17	18-19	All under 20	20-24	25-35
	%	%	%	%	%
a. Knows of local source	70	83	75	79	76
Knows of no local source but knows of a source	10	8	10	9	10
Knows of no source	20	8	15	12	13
b. Knows of a clinic	58	67	62	63	45
Knows of no clinic	40	28	35	36	55
No answer	2	6	3	2	0
<i>Base: single women 16-35 at risk who have never used the services = 100%</i>	106	72	178	67	38

It is apparent that in 1975 non-use of the services by single women at risk can rarely have been due to ignorance of the location of services.

(c) **Anticipated discomforts** On the whole changes between 1970 and 1975 in the anticipated discomforts of service use were small. The same proportion of never users at risk expected to be embarrassed in asking their own doctors for advice, and a rather greater proportion in 1975 than in 1970 foresaw the same at clinics. The small reductions in the percentages who thought that privacy would be inadequate at each source may be due to a change in question wording between the two surveys³ (Table 14.14).

Table 14.14 Proportions anticipating discomforts of service use—1970 and 1975—never users at risk

	At a Clinic		At own doctor (GP)	
	1970	1975	1970	1975
	%	%	%	%
Informant agrees that use of services would be:				
embarrassing	31	39	46	46
not private enough	21	14	15	10
not be the way to get sympathetic advice	42	36	52	38
<i>Base: single women 16-35 at risk who have never used the services = 100%</i>				
	519	283	519	283

Rather fewer of the 1975 than 1970 group expected that they would not get sympathetic advice from clinics, but the greatest change was the decrease in the proportion who thought their doctor would not give them sympathetic advice. Many of those in 1975 who did not expect this sort of advice said

³Informants were asked whether they agreed or disagreed with the statement that Clinics/GPs would be:
1970 'not private enough'
1975 'private enough'

(See question 18 of Interview schedule—Appendix 1). The reason for thinking the change is due to the question wording is given in Chapter 3, p. 16.

that it was not what they would look for anyway 'You just want advice, you don't want sympathy', but one of the commonest reasons given by the remainder for not expecting sympathetic advice from their doctor was the view that he would disapprove because they were unmarried. The reasons for the same expectation in 1970 were not elicited, but it is possible that an increased confidence amongst single women that their requests for contraceptive advice would be acceptable to their doctors contributed to the rise in the proportion who thought they would get sympathetic advice and this in turn may partly account for the increased popularity of GPs as potential sources of advice amongst never users.

The evidence reported earlier that the younger never users at risk were the most likely to prefer a clinic for the unmarried suggests that they may be more anxious than others about their reception at ordinary clinics and by GPs. In fact slightly larger proportions of the 16 to 17 year olds than of the 20-24 age group did expect to be embarrassed if they asked their GP for advice (55 per cent and 49 per cent respectively), and rather more thought they would not get sympathetic advice from their doctor (38 per cent compared with 31 per cent). The differences for clinics were in one case (embarrassment) very small and in the other, in the reverse direction⁴ (Table 14.15).

14.3 Experienced discomforts of service use—current and past users

This section is mainly concerned with what using the services had actually been like for the single women who had used them and the ways in which this had changed between 1970 and 1975. As in 1970, past and present users of each service are combined to provide adequate bases for analysis.

(a) **Accessibility and availability** Visits to clinics were less commonly reported as difficult to

⁴The type of clinic was not specified in the question (18) and some women may have been thinking of a clinic intended for the unmarried.

Table 14.15 Anticipated embarrassment and lack of sympathetic advice in using the services—according to age—1975 never users at risk

	Clinic					GP				
	16-17	18-19	All under 20	20-24	25-41	16-17	18-19	All under 20	20-24	25-41
	%	%	%	%	%	%	%	%	%	%
Informant agrees that use of services would be:										
embarrassing	38	42	39	34	48	55	40	49	49	27
not the way to get sympathetic advice	36	36	36	40	27	38	42	39	31	36
<i>Base: single women 16-40 at risk who have never used the services = 100%</i>										
	106	72	178	67	44	106	72	178	67	44

arrange in 1975 than in 1970; 33 per cent reported difficulties in the earlier year and 16 per cent in 1975, whilst the change in the case of GPs was negligible (2 per cent and 6 per cent respectively).

The longer time needed for a clinic than GP visit and the small changes between 1970 and 1975 were described for married women in Chapter 3, and since single women's experiences were much the same they are not reported here.

Similarly, the known availability of the services were very similar for single and married women and it is of more interest to consider the preferred times of day for visits by single women and the way these compared with the preferences of married women. The comparison indicates how compatible the choices of the two groups are.

Table 14.16 shows, as could be expected, that single women were more likely than married women to prefer evening visits to each source, but also that a larger proportion of the unmarried (although a minority) opted for lunch time visits to clinics. It is important that single women at risk who were never users had very similar preferences to the unmarried who had ever used the services.

Table 14.16 Most convenient visiting times for family planning advice—current service users—1975 married and single women

	Clinics		GPs	
	Married women	Single women	Married women	Single women
Most convenient visiting times: %	%	%	%	%
Mornings	29	13	44	21
Lunch times	5	12	4	6
Afternoons	20	12	15	17
Evenings	53	70	45	69
Base: married women current users, single women ever users = 100%	358	101	437	132

(b) **Attractiveness** In both years only a minority of users were critical of the comfort of service use and changes in experienced attractiveness of the services between 1970 and 1975 were small, but in the right direction. Rather fewer of the users in the most recent year had felt embarrassed in using each service, and rather more said they had received sympathetic advice. The reduction in the proportion reporting inadequate privacy, as noted previously, may be due to the change in question wording (Table 14.17).

14.4 Discussion

The information given by single women who had used the services confirms the picture which

Table 14.17 Experienced discomforts of service use—1970 and 1975—past and current service users

	At clinics		At own doctor (GP)	
	1970	1975	1970	1975
	%	%	%	%
Informants agree that use of service is:				
Embarrassing	23	18	24	19
Not private enough	20	12	19	8
Not the way to get sympathetic advice	33	30	36	36
Base: single women 16-35 who were past or current service users = 100%	30	99	59	126

emerged from married users: although the services were providing for more women in 1975 than in 1970, their quality had not deteriorated and had probably somewhat improved.

A much greater proportion of single women were using the services in 1975 than in the earlier year, and, although the survey provides no evidence, it seems likely that the change is part of a continuing trend which results from the gradual disappearance of taboos on pre-marital intercourse which have increased its prevalence and at the same time lowered inhibitions about seeking contraceptive advice.

Recent extra-marital conception rates indicate that not all the sexually active use effective contraception and that some may use none, but the only clue from the survey to how the services might be made more acceptable to the women at risk of intercourse who had never used them comes from the preferences informants expressed for different types of service. About a third of the under 20s (who formed the majority of never users at risk) chose a special clinic for the unmarried, and about 80 per cent of the women making this choice were under 20.

This suggests that the way of reconciling the requirements of the predominantly teenage never users at risk and the mainly older users who were evidently well served by existing arrangements is through the provision of additional clinics for the unmarried, designed particularly for the young. Such facilities, it seems would be most heavily used in the evenings.

However, it is likely that adequate provision of this kind will be expensive; that the demand for it may decline over the next few years (since there is a suggestion that it did so between 1970 and 1975); and that many of the youngest women who prefer clinics for the unmarried will not actually become sexually active until a later age when they are less likely to want such facilities.

If, as is possible, the desire for special clinics arises largely from anxiety about how requests for contraceptive advice from unmarried teenagers will be received, it may be that a clear indication in

national and local publicity that they are acceptable is all that is needed to reassure the younger girls who are inhibited about seeking necessary advice at the present time.

15 Use of contraception by single women

15.1 Changes in contraceptive use 1970-75

The reported use of contraception by single women (including methods used by their partners) increased considerably between 1970 and 1975. In the earlier year about a quarter of those under 36 said they had ever used contraception compared with 45 per cent in 1975. Amongst the women who did not reject the idea of pre-marital intercourse (those at risk) the increase was from 36 per cent to 60 per cent (Table 15.1).

Table 15.1 Percentages of single women who had ever used contraception—1970 and 1975

Whether had ever used contraception	All single women		Single women at risk	
	1970	1975	1970	1975
	%	%	%	%
Yes	24	45	36	60
No	74	55	59	40
Not known	2	0	5	0
<i>Base: single women 16-35 = 100%</i>				
	947	724	621	539

Most if not all of the increase could be accounted for by the massive rise in use of the pill (Table 15.2). In 1970, 9 per cent of all the single women interviewed had ever used the pill, whilst 36 per cent of the 1975 sample had done so. Similarly, 14 per cent of the women at risk in 1970 had ever used the pill, but 49 per cent of the corresponding 1975 group. This change was of course reflected in

the particular methods experienced by the women who had actually used contraception, and 80 per cent of those who had ever used contraception in 1975 had experience of the pill compared with less than 40 per cent of the smaller group of ever-users in 1970. Experience of the condom had also increased over the five years both amongst all single women and amongst those at risk, but the increase was relatively small, and amongst those in each year who had had experience of contraception the proportion reporting condom use had declined.

IUDs which were used by none of the single women interviewed in 1970 had been tried by 1 per cent of the 1975 sample. Even if this represents a real increase in use in the population of single women rather than sampling error, it does not suggest that IUDs are becoming popular amongst the unmarried.

Two other conclusions are suggested by Tables 15.1 and 15.2. Firstly, it seems that in 1975 at least 45 per cent of the single women under 36 were sexually experienced, whereas in 1970 the suggested proportion was in the region of 35 per cent.¹

Secondly, it appears that amongst those who had

¹The 1970 figure of 35 per cent was higher than the proportion who reported use of contraception (23 per cent) and was suggested in the light of evidence from other enquiries which cannot be used in 1975. (M Bone—*Family Planning Services in England and Wales*, London, HMSO 1973, p. 54.)

Table 15.2 Percentages of single women who had ever used various methods of contraception* —1970 and 1975

Method ever used	All single women		Single women at risk		Single women who had used contraception	
	1970	1975	1970	1975	1970	1975
	%	%	%	%	%	%
Withdrawal	4	3	6	4	17	6
Pill	9	36	14	49	39	80
IUD	0	1	0	2	0	2
Cap	1	2	2	2	5	3
Condom	16	22	26	30	69	49
Safe period	1	1	2	1	6	2
None	74	55	59	40	Not applicable	
Not known	2	0	5	0	0	0
<i>Base: single women 16-35 = 100%</i>						
	974	724	621	539	232	326

*Some rarely mentioned methods and spermicides (normally used with another method) have been omitted from this and the following tables. Two women said they had been sterilised.

used contraception, the 1975 women had been better protected than the corresponding 1970 group since a much higher proportion had used the pill which is a more effective method than any other, apart from sterilisation (see Chapter 8).

This suggestion, however, is made on the assumption that the effectiveness of the various methods is the same for single as for married women, and also in the absence of any information about patterns of contraceptive use over time and the way this is related to sexual attachments. In particular the fact that an unmarried woman has ever used the pill may not mean that she always uses it when she has a sexual attachment.

In 1975, the pill had been prescribed for the vast majority (96 per cent) of current service users at their last visit for advice or supplies including for 99 per cent of current GP users and for 93 per cent of clinic users.

One point must be made about the single women's reports of the methods they had used. In outline the procedure was to ask single women what contraceptive methods they had heard of, which of these they thought they would use when married and whilst single, and which if any of those they mentioned, they had already used (Questions 8-12 see Appendix 1). Unlike married women they were not shown a list of methods to remind them of any they had forgotten or to help them with names they found embarrassing. In the following year (1976) single women interviewed for the Family Formation survey² were shown a list of methods before being asked which if any they had used. The results suggest that the more cautious approach used in the present survey produced a spuriously low figure for the proportion who had used withdrawal.

15.2 The relationships between contraceptive use and the characteristics of single women

In the report on the 1970 survey, the relationships

*K Dunnell—Family Formation Survey—awaiting publication.

between contraceptive use on the one hand, and age and social class on the other, were examined only for women at risk of pre-marital intercourse. Comparable tables are given below, but because of the unknown association between being at risk and actual experience of intercourse, discussed in Chapter 13, tables showing the relationships for all single women in 1975 are also presented. For each characteristic, the 1975 situation will be described first before going on to examine changes since 1970 where comparable figures are available.

(a) **Contraceptive use and age** In 1975, the proportions of women who had ever used contraception increased over the age groups until the early 20s and then declined so that 26 per cent of 16 to 17 year olds had used a method at some time, 64 per cent of 20-24 year olds and 48 per cent of those over 30. Twenty per cent of the youngest girls and over half the 20-24 year old group had used the pill (Table 14.3).

The same pattern, but higher proportions of users, appeared amongst the women at risk of intercourse who are considered below in relation to comparable figures for 1970.

Use of specific methods by those who had used any, shows whether some groups are less likely than others to use the most effective. Table 15.4 shows that amongst the women who had used a method, a slightly lower proportion of teenagers than of women in their early twenties had used the pill.

In the report on the 1970 survey, the relationship between contraceptive use and the characteristics of the single women was examined for those at risk of intercourse only. It was seen in Chapter 13 that the proportion of single women at risk in every age group increased between 1970 and 1975, and Table 15.5 shows that amongst the larger proportions at risk the percentages who had never used contraception had declined and that use of the pill in particular had risen steeply in every age group.

Table 15.3 Use of contraception by single women, according to age—1975

Method ever used	Age at interview						
	All ages	16-17	18-19	All under 20	20-24	25-29	30-41
	%	%	%	%	%	%	%
Withdrawal	2	..	2	1	5	3	2
Pill	36	20	33	26	55	39	24
IUD	1	0	0	0	2	3	4
Cap	2	0	1	..	3	3	8
Condom	23	14	21	17	29	28	26
Safe period	1	0	1	..	2	0	2
None	55	74	57	66	36	52	58
Base: single women 16-41=100%	749	216	180	396	228	715	50

Table 15.4 Methods of contraception ever used by single women who had used contraception, according to age—1975

Method ever used	All ages	Age at interview				
		16-17	18-19	All under 20	20-24	25-41
	%	%	%	%	%	%
Withdrawal	6	2	4	3	8	5
Pill	80	78	77	77	85	72
IUD	2	0	0	0	3	7
Cap	4	0	1	1	5	10
Condom	50	54	49	51	46	60
Safe period	2	0	1	1	3	2
<i>Base: single women 16-41 who had used contraception = 100%</i>						
	337	55	78	133	147	57

Table 15.5 Use of contraception by single women at risk according to age—1970 and 1975

Method ever used	All ages	Age at interview				
		16-17	18-19	All under 20	20-24	25-35
	%	%	%	%	%	%
(a) 1975						
Withdrawal	4	1	2	1	6	4
Pill	49	29	46	37	67	45
IUD	2	0	0	0	2	5
Cap	2	0	1	..	4	4
Condom	30	20	29	24	36	35
Safe period	1	0	1	..	2	1
None	40	63	40	52	21	39
<i>Base: single women 16-35 at risk = 100%</i>						
	539	147	131	278	186	75
(b) 1970						
Withdrawal	6	4	5	5	9	6
Pill	14	4	11	8	22	23
IUD	0	0	0	0	0	0
Cap	2	0	1	..	2	9
Condom	26	17	23	20	36	30
Safe period	2	..	1	1	4	4
None	59	74	62	68	46	43
<i>Base: single women 16-35 at risk = 100%</i>						
	621	185	175	360	208	53

(b) **Contraceptive use and social class** The proportion of women who had ever used contraception was greatest for daughters of non-manual workers in 1975, and experience of the pill in particular declined with social class so that 42 per cent of the non-manual group had used the pill, but only 27 per cent of those in classes IV or V (Table 15.6). Amongst those who had ever used contraception, 83 per cent of non-manual and 76 per cent of manual women had used the pill; the difference in this case being mainly because only 67 per cent of Class IV and V had experience of the pill.

The same relationships were evident amongst the women at risk of intercourse, and although greater percentages in every class had ever used the pill or contraception of any kind in 1975 than in 1970,

the difference between the classes persisted (Table 15.7).

It was shown earlier that women in the manual group were on the whole younger than other single women (Chapter 13) and also that the women under 20 were least likely to have used contraception. As a result of these inter-relationships the class differences in contraceptive use within age groups were small for those under 20, but not for older women (Table 15.8).

Amongst teenagers, a greater proportion of the manual than non-manual group were at risk (see Chapter 13), but when only the women at risk are examined, the differences between the social classes within age groups under 20 remain small (Table 15.9).

Table 15.6 Use of contraception by single women according to social class—1975

Method ever used	All classes	Social class			
		Non-manual	Manual		Total
			III	IV & V	
	%	%	%	%	%
Withdrawal	2	2	4	1	3
Pill	36	42	34	27	32
IUD	1	1	1	0	1
Cap	2	3	1	1	1
Condom	23	26	20	22	21
Safe period	1	2	0	0	0
None	55	49	58	60	58
<i>Base: single women 16-41 = 100%</i>					
	749*	291	287	154	441

*Includes 17 women who were unclassified.

Table 15.7 Use of contraception by single women at risk according to social class—1970 and 1975

Method ever used	All classes	Social class			
		Non-manual	Manual		Total
			III	IV & V	
	%	%	%	%	%
(a) 1975					
Withdrawal	4	3	3	2	4
Pill	49	58	47	34	42
IUD	2	2	2	0	1
Cap	2	3	2	2	2
Condom	30	36	26	28	27
Safe period	1	3	0	0	0
None	40	30	42	50	45
<i>Base: single women at risk 16-35 = 100%</i>					
	539*	203	206	119	325
*Includes 11 women unclassified.					
(b) 1970					
Withdrawal	6	9	5	3	4
Pill	14	20	11	7	10
IUD	0	0	0	0	0
Cap	2	3	2	0	1
Condom	26	31	24	21	23
Safe period	2	3	2	1	2
None	59	52	60	67	63
<i>Base: single women at risk 16-35 = 100%</i>					
	621*	232	233	129	362

*Includes 27 women unclassified.

Within age groups the numbers of women who had ever used contraception are too small to give reliable information about population differences between the classes in the use of specific methods.

(c) Contraceptive use and being engaged or having a boyfriend The women who had neither boyfriends nor fiancés at the time of interview in 1975 were the least likely ever to have used contraception, but differences between those who were engaged and those with boyfriends were small (Table 15.10). Amongst the women under 20, however, a greater proportion of the engaged than of the girls with boyfriends had used contraception and particu-

larly the pill. The converse was true for 20-24 year olds.

Comparable figures are not available for 1970.

15.3 Anticipated contraceptive behaviour by women when not using a female method

In 1970 the majority of single women who had used contraception had relied on their partners to take precautions, since only about 40 per cent had used the pill, 5 per cent the cap and none the IUD. Although the situation had changed by 1975 (when 80 per cent of users had tried the pill, 2 per

Table 15.8 Use of contraception by single women according to age and social class—1975

Method ever used	Age and social class									
	16-17		18-19		All under 20		20-24		25-41	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
Withdrawal	0	1	0	2	0	2	5	6	4	2
Pill	17	22	39	30	27	26	62	49	39	28
IUD	0	0	0	0	0	0	1	2	4	2
Cap	0	0	0	1	0	..	3	4	9	2
Condom	12	22	22	21	17	18	33	26	35	23
Safe period	0	0	0	0	0	0	4	0	2	0
None	79	72	54	58	67	66	30	40	46	61
<i>Base: single women 16-41 = 100%</i>										
	66	148	59	119	125	267	109	113	57	61

Table 15.9 Use of contraception by single women at risk by age and social class—1975

Method ever used	Age and social class									
	16-17		18-19		All under 20		20-24		25-41	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
Withdrawal	0	1	0	4	0	2	6	8	5	2
Pill	28	30	52	42	41	35	74	60	60	35
IUD	0	0	0	0	0	0	1	2	5	2
Cap	0	0	0	1	0	..	3	4	14	2
Condom	20	21	30	29	25	24	40	33	54	29
Safe period	0	0	2	0	1	0	4	0	3	0
None	64	62	39	41	51	53	16	26	16	50
<i>Base: single women 16-41 at risk = 100%</i>										
	39	107	44	85	83	192	90	92	37	48

Table 15.10 Use of contraception by single women according to whether they had boyfriends or fiancés—1975

Method ever used	Engaged	Had boyfriend	Neither engaged nor has boyfriend	Method ever used	Engaged	Had boyfriend	Neither engaged nor has boyfriend
	%	%	%		%	%	%
(a) all single women				(c) aged 20-29			
Withdrawal	1	4	2	Withdrawal	2	8	4
Pill	50	45	19	Pill	57	63	42
IUD	1	1	1	IUD	0	2	3
Cap	2	1	2	Cap	3	2	4
Condom	24	31	12	Condom	22	39	22
Safe period	0	1	..	Safe period	0	2	3
None	41	44	74	None	38	25	48
<i>Base: single women 16-41 = 100%</i>				<i>Base: single women aged 20-29 = 100%</i>			
	135	325	289		60	97	71
(b) aged under 20							
Withdrawal	0	2	0				
Pill	45	34	10				
IUD	0	0	0				
Cap	2	0	0				
Condom	25	24	6				
Safe period	0	1	0				
None	42	57	86				
<i>Base: single women 20-29 = 100%</i>							
	60	176	160				

cent the IUD, and 3 per cent the cap) about half had had experience of the condom at some time and it therefore remains important to know what single women do if they are about to have intercourse and are not using the pill or IUD. The women at risk were asked whether in these circumstances they would ensure their boyfriend took

cent the IUD, and 3 per cent the cap) about half had had experience of the condom at some time and it therefore remains important to know what single women do if they are about to have intercourse and are not using the pill or IUD. The women at risk were asked whether in these circumstances they would ensure their boyfriend took

Table 15.11 Percentages of single women at risk predicting various kinds of contraceptive behaviour when not using contraception themselves—1970 and 1975

1 By age

Predicted contraceptive behaviour	All ages	Age at interview				
		16-17	18-19	All under 20	20-24	25-35
	%	%	%	%	%	%
(a) 1975						
Would ensure boyfriend used	81	79	87	83	81	75
Too embarrassing etc to mention	3	6	2	4	2	1
Probably not think about it at all	9	10	6	8	11	9
Situation would not arise	3	2	2	2	4	7
Other and not known	3	3	2	2	2	8
<i>Base: single women 16-35 at risk=100%</i>						
	539	147	131	278	186	75
(b) 1970						
Would ensure boyfriend used	70	65	73	70	73	62
Too embarrassing etc to mention	4	5	3	4	4	6
Probably not think about it at all	17	21	14	18	14	21
Situation would not arise	4	2	3	3	6	12
Other and not known	9	9	9	10	6	12
<i>Base: single women 16-35 at risk=100%</i>						
	621	185	175	360	208	53

2. By social class

Predicted contraceptive behaviour	All classes	Social class			
		Non-manual		Manual	
				III	IV & V
	%	%	%	%	%
(a) 1975					
Would ensure boyfriend used	81	85	83	72	79
Too embarrassing etc to mention	3	..	3	6	4
Probably not think about it at all	9	6	10	14	11
Situation would not arise	3	4	2	2	2
Other and not known	3	4	2	5	3
<i>Base: single women 16-35 at risk=100%</i>					
	539	203	206	119	325
(b) 1970					
Would ensure boyfriend used	79	73	70	66	69
Too embarrassing etc to mention	4	3	4	7	5
Probably not think about it at all	17	13	16	25	19
Situation would not arise	4	6	5	1	3
Other and not known	9	8	8	10	9
<i>Base: single women 16-35 at risk=100%</i>					
	621	232	233	129	362

Table 15.12 Percentages of single women at risk predicting various kinds of contraceptive behaviour when not using contraception themselves—by age and social class—1975

Predicted contraceptive behaviour	Age and social class									
	16-17		18-19		All under 20		20-24		25-41	
	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual	Non-manual	Manual
	%	%	%	%	%	%	%	%	%	%
Would ensure boyfriend used	80	78	96	84	88	81	83	79	78	73
Too embarrassing etc to mention	3	8	0	2	1	5	0	3	0	2
Probably not think about it at all	10	9	0	9	5	9	9	14	5	12
Situation would not arise	0	3	2	2	1	3	6	1	11	2
Other and not known	8	2	2	2	5	2	2	2	5	10
<i>Base: single women 16-41 at risk=100%</i>										
	39	107	44	85	83	192	90	92	37	48

precautions, find it too embarrassing or unromantic to mention or probably not think about it at all.³

In both 1970 and 1975, the majority of women at risk said they would ensure that their partner used contraception, but whilst 70 per cent of the 1970 women made this reply 81 per cent did so in 1975, and the change was accounted for mainly by a reduction in the proportion who said they would probably not think about it at all at the time, from 17 per cent to 9 per cent (Table 15.11).

The change applied to all age groups and every social class, but the youngest girls aged 16 to 17, and the manual group were in 1975 as in 1970 apparently a little less likely than others to be determined that contraception should be used and this was true within each age group (Table 15.12).

15.4 Discussion

The reported use of contraception and especially of the pill had greatly increased between 1970 and 1975. This was true not only for single women as a whole but also for the group at risk of pre-marital intercourse, which comprised a larger proportion of single women in 1975 than in 1970. The inferences which can be drawn from the survey either about how these changes are related to the reduction in pre-marital conception rates, or what can be done through the services and health education to accelerate the current decline in the rates, are limited by the absence of information about the actual sexual experience of single women.

To begin an attack on the first question it would be necessary at least to know the prevalence of current sexual relationships and contraceptive

practice amongst single women at the time of each survey.⁴

To produce cogent answers to the second, we should need to obtain histories of sexual attachments and contraceptive use from single women and to find out from the relationship between patterns of attachments and contraception, the situations in which inadequately protected intercourse most commonly occurs. Is it, for example, when sexual experience begins, does the risk increase at the beginning of any new involvement or towards the end of faltering attachments; in steady or casual relationships? And do such patterns vary with age and social characteristics?

An example of the way the dissolution and formation of relationships might affect contraceptive practice was suggested by the present survey. The commonest reason given for abandoning the services (apart from unexplained decisions not to use the prescribed method) was that a relationship with a former boyfriend or fiancé had ended. Where new relationships begin after the women concerned have stopped taking or finished their last supplies of pills, there could be a heightened risk of inadequately protected intercourse, especially if men have come to assume that their partners will be using the pill. Even if the women begin using the pill again before resuming intercourse, oral contraceptives are not considered to be fully effective until they have been used for 14 days following the 4th day after menstrual bleeding begins.⁵

Answers to the questions suggested above would indicate the kind of situations and groups on which administrators and health educators should focus their attention, the type of contraception most suited to these circumstances and the sort of information and encouragement most likely to succeed.

³In 1970 the first category was 'insist your boyfriend took precautions'. 'Insist' was changed to 'ensure' in 1975 because this seemed to correspond better with the real situation. Since the alternatives were unchanged there is no obvious reason why this should alter responses.

⁴This information is available for 1976 from the Family Formation Survey—K. Dunnell (awaiting publication).

⁵*Handbook of contraceptive practice*—DHSS, 1974, p. 11.

16 Summary and Discussion

16.1 The scope for improved contraception in 1970 and subsequent changes

In 1970, the year of the earlier survey, the great majority of married women or their husbands were using contraception. Unwanted pregnancies,¹ if they occurred, usually began during periods of contraceptive use, which sometimes included occasional omissions. Certain groups of women, like those who married before they were 20 and those who conceived before marriage were particularly prone to unwanted pregnancies throughout the course of their married lives. Consequently, it was suggested in the report on the 1970 survey that a reduction in unwanted pregnancies within marriage would occur if a greater proportion of couples adopted the most effective methods of contraception, and if contraceptive use in the earliest period of marriage and before marriage were to increase.

Between 1970 and 1975 all the changes which were thought to be necessary to reduce excess pregnancies occurred. Use of the pill, the most effective reversible method (see Chapter 8 and Section 2 below) grew so that in 1970 about 20 per cent of married women under 41 who thought they could still conceive relied on the pill, but 36 per cent in 1975: amongst the group who had married after 1970 the proportion using the pill was much higher—60 per cent. The incidence of sterilisation (discussed further in Section 2) had also risen sharply so that a considerable proportion of couples in the later natural child-bearing period could no longer have children for this reason.

At the same time use of contraception, and particularly of the pill, had increased in the period immediately after marriage. This is part of a trend which can be traced to the beginning of the century, but which probably gained momentum from the time the pill was introduced in 1961.

Amongst single women the use of contraception and especially of the pill expanded between 1970 and 1975, and whilst about a quarter of those aged 16 to 35 in 1970 reported experience of contraception, approaching half (45 per cent) of the same age group interviewed in 1975 were similarly experienced. The proportion who had used the pill had grown from 9 per cent to 36 per cent.

¹Unwanted pregnancies are those which informants said they were sorry had occurred at the time they first realised they were pregnant.

Single women were not asked about their sexual experience in either year and it is therefore impossible to say to what extent the expansion of contraceptive use reflected the spread of sexual activity rather than of prudence amongst single women. But evidence from national statistics of conception rates amongst unmarried women indicates the continuing scope for improved contraceptive practice amongst sexually active single people.

These changes in contraceptive use had been accompanied by a slight fall in the proportion of pregnancies reported by married women as unwanted, from 17 per cent to 14 per cent. The fall was due to the more considerable decline amongst the groups of women who were the most likely to have unwanted pregnancies: for example women married to semi or unskilled manual workers interviewed in 1970 said that 24 per cent of their last pregnancies were unwanted, but in 1975 the corresponding figure was 17 per cent. The reduction in the number of unwanted pregnancies is greater than this suggests, since the total rates and numbers of pregnancies within marriage had declined, partly because of a fall in unplanned pregnancies which include most unwanted ones.

16.2 The pill and sterilisation

(a) **The pill** Except in the earliest period of marriage, the growth in the use of the pill largely represented its substitution for other methods formerly used by married couples. The value of the change therefore depends on whether it proved to be more effective in practice than the likely alternatives.

Almost all enquiries have shown the pill to be the most effective reversible method, and not surprisingly the 1975 survey yielded the same result. On average five failures were experienced by every hundred women during the first year they used the pill. This compared with a failure rate of 11 per cent for the condom, the other most commonly used method. The superior performance of the pill evidently arises because its failure rates are consistently comparatively low and vary less than those of other methods from one stage of family building to another or over time.² Thus although similarly low rates can be and have been achieved by couples

²The reported failures will include those due to the method and those due to the way it was used (see Chapter 8).

using the condom, the range has been much wider.

One reason for the absence of marked variation in the performance of the pill may be that its contraceptive effects outlast the period of its use: a group of women who give up the pill in order to get pregnant take slightly longer to conceive, on average, than a group who give up other methods for the same purpose. This was demonstrated by an earlier investigation of a clinic population³ and is corroborated by the present survey.

One implication of the evidence is that occasional omissions to take the pill, even if sequential are less likely to result in conception than similar omissions of other methods.

Probably largely because of the high effectiveness of the pill and the expansion in its use contraceptive failure rates in general declined. For example in the period immediately after marriage the number of contraceptive failures had fallen between the late 1950s and early 1970s from 15 to 7 for every hundred women during the first year of use.

The pill is the method most commonly obtained from the family planning services and in view of the evidence above there can be no doubt that they have been providing the most effective reversible contraceptive method.

(b) **Sterilisation** Although the proportion of couples who had been sterilised had doubled between 1970 and 1975, the figure for the later year is not dramatic: 13 per cent of the women under 41 or their husbands had been sterilised compared with 6 per cent of the corresponding 1970 group. But the overall figure for 1975 conceals the speed and dimensions of the change which was occurring, and notably that at least a quarter of the women in their early 30s at the time of the survey, or their husbands, were likely to have been sterilised by the time the women reached age 35.

More generally it seemed that the role of sterilisation was changing from a method of last resort for those who had already had more children than average to a method preferred by many comparatively young couples soon after their second or third child had been born.

16.3 Contemporaneous changes in the family planning services

The pill can only be obtained through the family planning services, that is GPs and clinics (or

private doctors who are rarely used) and is the method they most commonly dispense. The rise in the use of the pill between 1970 and 1975 therefore accompanied an increasing use of the services. In 1970, 27 per cent of married women under 41 who thought they could still conceive were users of the services compared with 44 per cent in 1975. Amongst all single women aged 16-55 the corresponding figures were 6 per cent and 24 per cent.

As described in Chapter 1, a number of developments have occurred in the services over the last decade of which the most notable have been the transfer of responsibility for them to the NHS and the introduction of free advice and prescribed contraceptive supplies—from clinics in 1974, and from GPs in 1975. Concurrently the number of clinics increased.

It proved difficult to show that the growth in service use was a result of these developments, in part because the evidence suggests that this increase began earlier and probably around the time that the pill became generally available in 1961. It is therefore possible that the introduction and growing popularity of the pill rather than changes in the services stimulated their use. However, the removal of charges was not completed until the period in which the survey was being carried out, and its full effects on service use would not have been apparent at the time. On the other hand, charges made at clinics for prescribed methods were removed a year before the survey, and it appeared that clinic use had grown more rapidly than GP use between 1970 and 1975, and especially among the wives of manual workers. Since this group of women were more likely than others to find clinic use expensive in 1970, it may be that the provision of free supplies had promoted use of the services and particularly amongst groups who were formerly least inclined to use them.

Although many more women in 1975 than in 1970 knew where they could get contraceptive advice locally, the experiences of those who used them in each year were remarkably similar: on the whole they were neither more nor less pleasant or easy to use. However, the time women had to wait at clinics before seeing the doctor (longer than at GPs in both years) had on average been a little reduced and more morning sessions were reported. GPs who provided a readily accessible service in both years were more often in 1975 than in 1970 seen as sympathetic advisers on contraception.

In view of the considerable increase between the two years in the numbers of women using the services the evidence that there had been some improvements in provision and no deterioration in any aspect examined can be seen as a success.

³M Vessey, R Doll, R Peto, B Johnson & P Wiggins (1976)—A long term follow-up of women using different methods of contraception—an interim report. *J Biosoc sci* (1976), 8, 373-427.

16.4 Older women and the contraceptive gap

A relatively high proportion (18 per cent) of currently married women aged 40-54 who believed they were still capable of child bearing were using no contraception. In the majority of cases the history of the women concerned suggested that they had little chance of conception despite their belief in their fecundity. A small number of the group, however, were evidently using no method because they had been advised to discontinue or not to use the pill, and evidently disliked the alternatives they knew of. This illustrates a problem which is likely to grow in the future. The generations which follow are much more likely to rely on the pill in early married life. If it becomes common practice to advise women over 35 to discontinue use of the pill, the need for acceptable and equally effective alternatives will become urgent. Even though the demand for sterilisation may consequently increase, it is unlikely to be chosen by every couple after they have decided to have no further children.

16.5 Contraception and the decline in fertility

There has been a continuous increase in the use of the pill since its introduction in 1961. On the evidence it seems possible, although not certain, that the event initiated a surge in the use of contraception and increasingly effective contraceptive practice. More recently, the growing popularity of sterilisation has further reduced the chances of unintended pregnancy.

These trends have accompanied a continuous decline in the annual number of births from a peak in 1964 so that currently fertility is below replacement level.⁴ Were the developments in contraceptive use responsible for this decline?

With the qualification described later no contraceptive method, however effective, can bring about a reduction in fertility unless people wish to limit their child bearing to or below the level attained. The answer to the question posed above therefore turns on whether the 'contraceptive revolution'⁵ made possible a limitation in child-bearing which had been desired but not achieved before the new methods became available or whether, on the other hand, their introduction and adoption merely coincided with a fall in the desired frequency of child-bearing.

The decline in fertility has, especially in the 1970s, been composed of two strands: a reduction in higher order births and a postponement of first births, together with some possible increase in childlessness.

⁴Replacement level is attained when each generation of women produces a replacement for themselves and for each male of that generation.

⁵The term used by C F Westoff & N B Ryder (1977) in their book of that title—Princeton University Press, Princeton, New Jersey.

The same trends were evident from the pregnancy histories reported by the married women in the 1975 survey. On the basis of a comparison of all and planned pregnancy rates, described in Chapter 9, it is argued that the fall in third and fourth pregnancy rates was largely although not entirely brought about by improved contraceptive practice rather than by a change in intentions. On the other hand, the reduction in the rates of first pregnancies after marriage (pre-marital conceptions were excluded) seemed to be mainly due to changed intentions: a new desire to defer or avoid conception after marriage.

The first trend—the reduction in later unplanned pregnancies—was especially marked amongst the wives of manual workers: and therefore tended to reduce the historic difference in fertility between the social classes. The deferment of first pregnancies was evidently most characteristic of the wives of non-manual workers, and so acted to widen the difference between the classes at the inception of family formation.

An incidental finding of the analysis was the way that second pregnancies followed—by choice—increasingly soon after the first from at least the early 1950s until the end of the 1960s and that the gap between them only widened again in 1971-75.

The earlier statement that efficient contraception will only reduce fertility in so far as people want it to do so, presupposes that the contraceptive effects of the method last no longer than intended by its users. As described earlier and in Chapter 10, it seems that the contraceptive effects of the pill on average slightly exceed the period of its use. If this is not recognised and allowed for by the women who use it, it will depress their fertility somewhat below the intended level.

Sterilisation will act in a similar way. Although it is presumably accepted as irreversible at the time it is carried out, at least some of those who are sterilised later change their minds and want another child.⁶ When deuterisation is not possible, the fertility of the couples concerned will also be below the desired level.

The analysis of the survey evidence used in this report therefore suggests that the modern methods of contraception, distributed through the family planning services, have been responsible for some but not all of the fertility decline evident in this country since 1964, and this is because they enabled people to restrict their child-bearing much nearer to the level they had been trying to reach in the immediate past. If this interpretation is correct, the family planning services, as the distributors of the modern methods, have been successful in reducing unplanned pregnancies. Not all

⁶M L Winston (1977) Why 103 women asked for reversal of sterilisation, *British Medical Journal* 30:3.77.

unplanned pregnancies are unwelcome, but the decline in unwanted pregnancies between 1970 and 1975—which was small in general, but greatest for the groups most likely to have unwanted pregnancies—may also be reasonably attributed to the provision of the new methods of contraception by the services.

Similar conclusions have been drawn by Westoff and Ryder about the role of modern contraceptive methods in the contemporaneous decline of fertility in the United States.⁷ The recent experience of the two countries alone, however, does not show that the decline could only have occurred with the aid of these methods. The experience of other periods when they were not available—especially the 1930s and early 1940s—and of other western countries, where they are evidently less used,⁸ indicates that fertility declines to low levels can be achieved through traditional means of birth control.

16.6 What remains to be done

Unwanted pregnancies amongst married women had not dwindled away by 1975 and the number of pre-marital conceptions for young women although falling remained considerable. It may be doubted that contraception alone, however effective, will ever eliminate the problem, but the evidence of the survey is that modern methods have played some part in reducing it, at least amongst married women.

As virtually the sole providers of these methods, the family planning services have a special responsibility to be as easy and pleasant to use as possible, so that no one is prevented from using the most effective methods because of inadequacies in the services. The main area in which there seemed to be scope for their improvement had to do with women's feelings of embarrassment in using them—although only a minority reported feelings of this kind. The findings indicated, firstly, that more privacy was needed at reception and in the waiting rooms, of clinics in particular, and it was suggested earlier that the necessary changes could be brought about by alterations of procedure and organisation at little if any extra cost.

Secondly, although only a small proportion of women who had never used the services strongly disliked internal examinations, it seems worth reconsidering their routine use in clinics. Except when an internal examination is necessary because of the method chosen, it might be preferable that

service users should be told that it is a screening device for gynaecological disorders and left to decide whether or not to have it.

A quarter of the women who had not used the services said they would prefer contraceptive advice from a woman doctor. Most doctors in clinics are women, but the great majority of GPs are men and the (publicised) provision of more female GPs specifically to give contraceptive advice might remove one deterrent to service use.

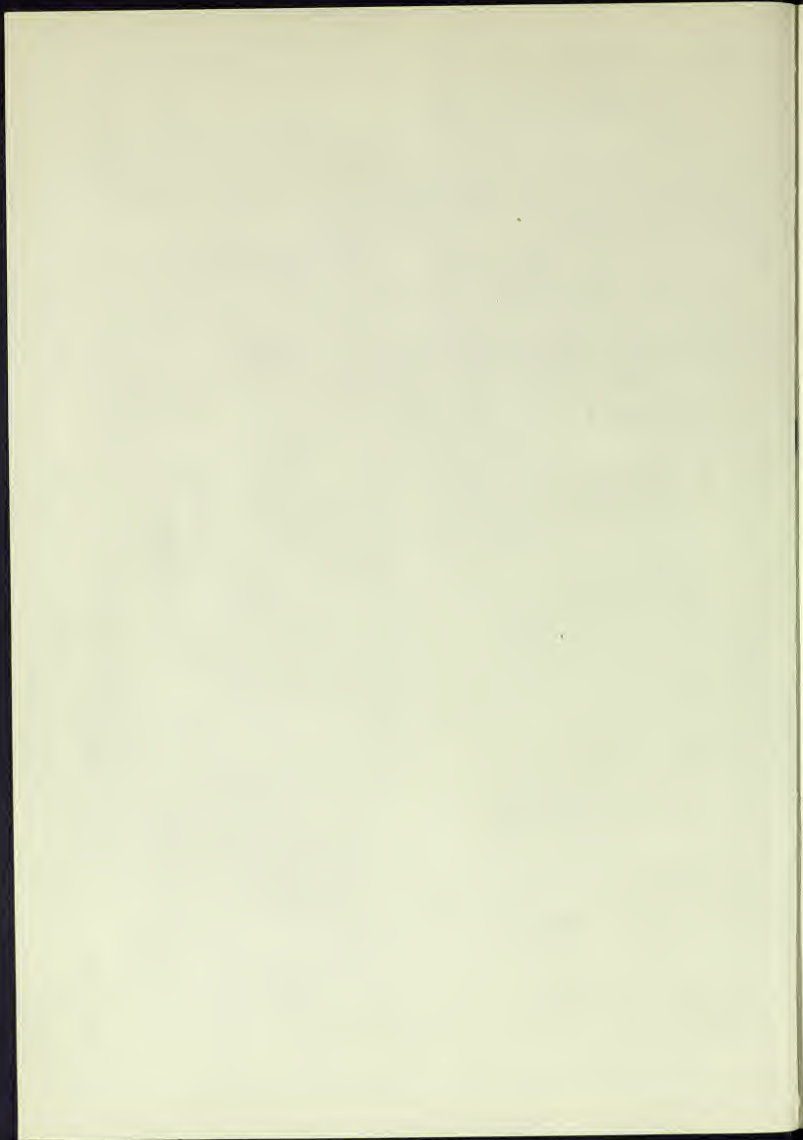
The greater confidence single women felt about using the services in 1975 compared with 1970 is implied not only by the greater proportion who actually did so, but also by the reduced preference for special clinics for the unmarried (compared with GPs and other clinics) amongst those who had not. It was suggested in the earlier report that the idea of such clinics was popular at the time because they reassured single women that their requests for contraceptive advice would not be met with disapproval. Nevertheless, although the demand for special clinics had declined they remained the preferred source for about a third of the girls under 20 who had never used the services and were liable to have sexual relationships. Clinics or special sessions for the unmarried are rare; only 4 per cent of the single women who had used the services in 1975 had attended one. An increase in these facilities—particularly in the evenings—might well persuade more of the younger women who need contraceptive advice to ask for it.

The key question about single women is why so many of them still get pregnant despite the availability of effective contraception. It is a question not answered by this or other investigations and requires research specifically designed to tackle the problem. It may be that the already apparent decline in pre-marital conceptions cannot be hastened by education, service provision or any other action in the power of administrators but if, on the other hand, such action can influence the trend it is most likely to do so if based on evidence of the causes of pre-marital conception.

A second area requiring further research is highlighted by the survey evidence of a major growth in sterilisation rates. Since sterilisation is affecting an increasingly large proportion of couples it is important to know more about its social, psychological and unintended physical consequences, as well as its failure rates. This is especially so because of the evidence that sterilisation is becoming less an alternative to excessive child-bearing than a substitute for other effective means of contraception soon after the second or third child is born. Since men are becoming at least as likely as women to be sterilised it is essential that they be included in studies of this kind.

⁷C F Westoff & N B Ryder (1977) *Op cit*.

⁸United Nations (1976) *Fertility and Family Planning in Europe around 1970: a comparative study of twelve national surveys—Population Studies No. 58*—United Nations, New York 1976, p 148 *et seq*.



S/1055

FAMILY PLANNING SERVICES II

MARRIED WOMEN

Interviewer's Name.....Auth No.

Day Mch Yr

Address No.

Pers. No.

Serial No.

<p>(A) At what type of address does the informant live?</p> <p>(B) Is the informant's name on the address list?</p>	<p>Responding</p> <p>Non-responding</p> <p>Yes</p> <p>No</p>	<p>1</p> <p>2</p> <p>1</p> <p>2</p>	<p>GO TO (B)</p> <p>GO TO Q.1</p>
<p>1. First of all can you tell me what the words "family planning" mean to you? (IF NECESSARY, PROMPT: When you see the words "family planning" that do you think of?)</p>	<p>Responding</p> <p>Non-responding</p> <p>Yes</p> <p>No</p>	<p>1</p> <p>2</p>	<p>GO TO (B)</p> <p>GO TO Q.1</p>
<p>2. What places or people do you know of that give advice on contraception that you could get to easily?</p> <p style="text-align: center;">↓</p> <p>LIST PLACES MENTIONED BELOW</p>	<p>Knows none X</p> <p>Knows 1 or more places/people</p>	<p>1</p>	<p>ASK (a)</p>
<p>(a) Do you know of anywhere at all that gives advice on ways of preventing pregnancy?</p>	<p>Yes</p> <p>No</p>	<p>2</p> <p>3</p>	<p>ASK (b)</p> <p>GO TO Q.3</p>
<p>(b) What places or people do you know of?</p> <p style="text-align: center;">↓</p> <p>LIST PLACES MENTIONED BELOW</p>	<p>Responding</p> <p>Non-responding</p> <p>Yes</p> <p>No</p>	<p>1</p>	<p>ASK (a)</p>

BIRTHS AND PREGNANCIES

I should like to talk to you about pregnancies you may have had, so may I first ask you about all the babies you have given birth to?

5. In the first place, do you have any children of your own living with you - that is, those you have actually given birth to?

(a) How many live with you?
Do you have any children of your own who do not live with you?

(a) How many do not live with you?

7. Have you ever given birth to a child who later died - even one who only lived for a short time?

(a) How many of your children have died?
A + B + C = TOTAL LIVE BORN CHILDREN

8. So you have had D children born live. Is that correct?

HOW MANY OF YOUR CHILDREN, BUT CODE
TOTAL NUMBER OF PREGNANCIES AT BOX E

9. In case any of your children were twins and so on, and each of many other pregnancies have you had which resulted in the birth of at least one live born child?

10. Are you pregnant now?

(a) When is the baby due?

11. INTERVIEWER CODE

12. A. Have you ever been pregnant - I mean have you ever had a pregnancy, even one that lasted only a few months or weeks or resulted in a stillbirth?

OR

B. Apart from the time(s) you have told me about, have there been any other times you were pregnant, even if the pregnancy lasted only a few months or weeks or resulted in a stillbirth?

(a) How many of these pregnancies have you had? RECORD NO. TOTAL PREGNANCIES (E + F + C)

13. So altogether you have been pregnant H times, (including your present pregnancy). Is that right?

3. Do you think that on the whole enough information is provided for you to decide whether you need further family planning services or not?

GO TO Q.5
ASK Q.4
GO TO Q.5

Yes
No
Other (specify)

4. In what way do you think things could be improved?

ASK (a)
GO TO Q.6

A

ASK (a)
GO TO Q.7

B

ASK (a)
RECORD TOTAL

C

D

GO TO Q.9
AMEND BOXES
D CHILDREN
ASK Q.9

E

F ASK (a)
GO TO Q.11

ASK Q.12.A
ASK Q.12.B

ASK (a)
ENTER IN
BOX THEN GO
TO Q.16, p.6

ASK (a)
SEE BELOW

G H

GO TO Q.14
AMEND BOXES
A - H

Qs. 14 - 15 BIRTHS AND PREGNANCIES

OFF. USE ONLY	CHILD'S NAME	Most recent marriage dates		A		B		C		D		E		F			G		H
		Mth	Yr	PCY NO.	DATE PREGNANCY ENDED		SEX	CURRENTLY PREGNANT?	STILL LIVING?	LIVED A YEAR		DURATION OF PREGNANCY		VITAL SIGNS		SEX			
					Month	Year				M	F	Yes	No	Yes	No		Actual	Less than 7 mths		7 mths or more	Yes	No	M	F
	FIRST CHILD																		
	SECOND CHILD																		
	THIRD CHILD																		
	FOURTH CHILD																		
	FIFTH CHILD																		
	SIXTH CHILD																		
	SEVENTH CHILD																		

LIVE BIRTHS

I'd like first to talk about all your live births.

14. In what month and year did your (first, second) birth occur?

(a) Was it a boy or a girl?

(b) Is this child still living?

IF YES

(1) What is his/her name?

IF DEAD

(11) Did the child live for more or less than a year?

ASK FOR ALL LIVE BIRTHS AND RECORD IN TABLE OPPOSITE, ON CHILD LINES IN CHRONOLOGICAL ORDER. THEN ASK QUESTIONS BELOW ABOUT NON LIVE BIRTHS.

NON LIVE BIRTHS

(Now) can I ask about the pregnancy (ies) you had which did not result in a live birth.

15. In what month and year did your first such (second such) pregnancy end?

(a) How many months did that pregnancy last?

IF SEVEN OR MORE MONTHS

Did that baby show any signs of life after it was born?

IF YES

(1) Was the baby a boy or a girl?

INTERVIEWER RECORD

Is informant currently pregnant?

16. As far as you know, could you (and your husband) have conceived (or did you) if (after this pregnancy ends) or would it be difficult, impossible or dangerous to your health?

ENTER IN COLUMN A OPPOSITE

COLUMN B

COLUMN D

FIRST COLUMN OPPOSITE

COLUMN E

(a) Have you any reason for thinking it might be difficult, impossible or dangerous?

Has reason }
D/K }
Has no reason }

17. Why do you think it would be difficult or impossible for you and your husband to have (more) children?

PRIORITY

Because of operation
Because of injury
Because of change of life
Menopause (change of life)
Other (specify)

(a) (Could I just check) is the difficulty: PRIORITY

Setting pregnant having a baby born alive or because it would endanger your health?

(b) When did the last period you had begin?

One month ago or less
More than 1 month but less than 3 months
3 months or more, but less than 6 months
6 months or more but less than 1 year
1 year or more

18. INTERVIEWER CODE

Couple could conceive (again)

Uncertain

Would be difficult/impossible for couple to conceive (again)

19. (Could I just check) do you expect to have (more) children at all (after this baby)?

Yes/maybe
No
D/K

THOSE WHO HAVE HAD AN OPERATION

20. (Could I just check) was it you or your husband who had the operation?

Q.17, CODE 1

GO TO Q.22

DNA: Has not had operation X
Informant
Husband

21. Has this operation performed mainly to prevent your becoming pregnant again, or for some other reason?

For some other reason (specify)

To prevent pregnancy (specify)

1 ASK (a) & (b)
GO TO Q.22

(a) Was this because you wanted no (more) children, because (another) pregnancy would have been dangerous to your health, or for some other reason?

Wanted no more children
Dangerous to health
Other reason (specify)

1 MORE THAN
ONE MAY BE
CODED

(b) In what month and year did you/your husband have this operation?

MONTH
YEAR

22. INTERVIEWER CODE

REFER TO Q.12
BOX H

Has been pregnant X
Has never been pregnant Y

ASK Q.23
GO TO Q.24

23. Thinking about your last (present) pregnancy, when you first realised you were pregnant what was your immediate reaction?

RUNNING
Were you pleased
Did you wish it had happened earlier
or were you sorry it had happened at all?
later
Combination of reactions (specify)/Other (specify)

1
2
3
4
5
SINGLE CODE

CONTRACEPTIVE KNOWLEDGE

SHOW CARD A.

24. Now I want to talk about a somewhat different topic. There are various ways that a couple can delay the next pregnancy or avoid pregnancy. Can you tell me this card and tell me which of these methods you have heard of:

PROMPT Qs 23-32 OPPOSITE AND RECORD ANSWERS IN COL. 1

DNA: Sterile X

All others Y

33. Which of the methods you mentioned would you definitely not want to use, or not want to use again?

PROMPT METHODS HEARD OF

Would use all methods heard of (again) X

Would not use one or more methods (again) Y

RECORD/UNCERTAIN
Q.18
CODES 1 AND 2

GO TO Q.34
PAGE 10
ASK Q.33

GO TO Q.34,
PAGE 10
RECORD
METHODS
REJECTED IN
COL. 2
OPPOSITE

MARRIAGE HISTORY

34. (May I check) are you now:

1 ASK Q.35
2 married
3 widowed
4 divorced
separated?

35. Have you been married (lived with someone) more than once?

Yes
No

1 ASK Q.37
2 GO TO Q.38

36. Were you married more than once?

Yes
No

1 ASK Q.37
2 GO TO Q.38

37. How many times have you been married (lived with someone) altogether?

NUMBER

.....

38. In what month and year did your (first, second...)

IF MARRIAGE
IN QUESTION
WAS YOUR
FIRST, WRITE
CODE IN BOX
THEN

IF MARRIAGE ENDED

(a) How did the marriage end - by death, divorce or separation?

IF DIVORCE OR SEPARATION

(b) In what month and year did you stop living together?

IF DEATH

(c) In what month and year did he die?

	WHEN MARRIAGE BEGAN		HOW ENDED				WHEN MARRIAGE ENDED	
	Month	Year	con- tinue	Death	Div.	Sep.	Month	Year
1			1	2	3	4		
2			1	2	3	4		
3			1	2	3	4		
4			1	2	3	4		

ENTER DATES
OF START
(AND END) OF
MOST RECENT
MARRIAGE
ON PAGE 4.
GO TO Q.39

39. IF MARRIED BUT HUSBAND NOT IN HOUSEHOLD

DNA: Husband in household X
DNA: Widowed/divorced/separated Y

(a) As your husband is not in your household at present, may I check is that because the marriage has ended or for some other reason?

1 ASK (b)
2 Marriage ended
Other reason

(b) In what month and year did you stop living together?

MONTH
YEAR

10

9

	Col.1.1		Col.1.2		Q.33
	Yes	No	Would not use (again)		
25. WITHDRAWAL, THE MAN IS CAREFUL AND PULLS OUT BEFORE CLIMAX	1	A	1		
26. THE PILL, OR ORAL CONTRACEPTIVE	2	B	2		
27. I.U.D., COIL OR LOOP, INTRAUTERINE DEVICE	3	C	3		
28. (a) DIAPHRAGM, CAP OR DUTCH CAP - WITH SPERMICIDAL CREAM	4	D	4		
(b) DIAPHRAGM, CAP OR DUTCH CAP - WITHOUT SPERMICIDAL CREAM	5	E	5		
29. (a) CONDOM, SHEATH, DUREX OR FRENCH LETTER - WITH SPERMICIDAL CREAM OR TABLETS	6	F	6		
(b) CONDOM, SHEATH, DUREX OR FRENCH LETTER - WITHOUT SPERMICIDAL CREAM OR TABLETS	7	G	7		
30. RHYTHM OR SAFE PERIOD	8	H	8		
31. ABSTAIN - NOT HAVING INTERCOURSE FOR SEVERAL MONTHS TO AVOID GETTING PREGNANT	9	I	9		
32. ANY OTHER METHODS Have you ever heard of any other methods which women or men use to avoid pregnancy? IF YES (SPECIFY) (i)..... (ii)..... (iii)..... (iv).....	J		X		
			X		
			X		
			X		

INTERVAL BETWEEN START OF PRESENT/MOST RECENT MARRIAGE AND 1ST PREGNANCY OF MARRIAGE.

SEE PAGE 4

DNA: Never pregnant during current/most recent marriage X DNA If has said		GO TO Q.50, P.17	INTERVIEWER CODE		Interval between _____ pregnancy and _____ pregnancy	NO. OF PAGES OF Q.42 - Q.43
40. Thinking back to the time before you became pregnant for the first time after you married (most recent pregnancy), did you or your husband (partner) use any of these methods to delay or prevent your becoming pregnant?		1	GO TO Q.42 P.12		SEE P.4	
Yes		1	ASK (a)(b)			
No		2	GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL			
(HAND CARD A TO INFORMANT)						
(a) What methods did you use, starting with the first you used:		1st				1 ASK (c) GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL
RECORD IN ORDER USED		2nd				2
		3rd				
		4th				
(b) Did you become pregnant while using the (most recent method) or had you stopped using it before becoming pregnant?		1 Still using 2 Stopped	GO TO Q.41			
		3	ASK (c)			1 GO TO Q.43 2 Stopped 3
(c) Did you stop using the (most recent method) in order to become pregnant?		1 Yes 2 No	GO TO Q.41			1 ASK (c) GO TO Q.43
THOSE WHO USED 1 OR 2 METHODS ONLY						
DNA: Used 3 or more methods X			GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL			GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL
41 (a) In what month and year did you start to use (FIRST METHOD)?		Month E Year				
(b) In what month and year did you stop using (FIRST METHOD)?		Month E Year				
DNA: Used 1 method only X			GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL			GO TO Q.42 OR Q.44 IF THIS IS LAST INTERVAL
(c) In what month and year did you start to use (SECOND METHOD)?		Month E Year				
(d) In what month and year did you stop using (SECOND METHOD)?		Month E Year				
11						

NO. OF PAGES OF Q.42 - Q.43		SEE P. 4	
INTERVIEWER CODE	Interval between pregnancy and pregnancy		
(USE CARD A)			
42. Think back to the interval between the end of your (first, second, third, etc) pregnancy and the time you next became pregnant. In that interval did you or your husband (partner) use any of these methods to delay or prevent your becoming pregnant?			
ASK (a)	Yes	1	2
GO TO Q.42	No		
OR Q.44 IF THIS IS LAST INTERVAL			
(a) What methods did you use, starting with the first you used:			
1st			
2nd			
3rd			
4th			
RECORD IN ORDER USED			
(b) Did you become pregnant while using the (most recent method) or had you stopped using it before becoming pregnant?			
1	While using	1	2
2	D/K		
3	Stopped		
(c) Did you stop using the (most recent method) in order to become pregnant?			
1	Yes	1	2
2	No		
THOSE WHO USED 1 OR 2 METHODS ONLY			
43. (a) In what month and year did you start to use (FIRST METHOD) after your (first, second, etc) pregnancy ended - that is, the one that ended in....?			
Month			
Year			
(b) In what month and year did you stop using (FIRST METHOD)?			
Month			
Year			
(c) In what month and year did you start using (SECOND METHOD)?			
Month			
Year			
(d) In what month and year did you stop using (SECOND METHOD)?			
Month			
Year			

NO. OF PAGES OF Q.42 - Q.43		SEE P. 4	
INTERVIEWER CODE	Interval between pregnancy and pregnancy		
(USE CARD A)			
42. Think back to the interval between the end of your (first, second, third, etc) pregnancy and the time you next became pregnant. In that interval did you or your husband (partner) use any of these methods to delay or prevent your becoming pregnant?			
ASK (a)	Yes	1	2
GO TO Q.42	No		
OR Q.44 IF THIS IS LAST INTERVAL			
(a) What methods did you use, starting with the first you used:			
1st			
2nd			
3rd			
4th			
RECORD IN ORDER USED			
(b) Did you become pregnant while using the (most recent method) or had you stopped using it before becoming pregnant?			
1	While using	1	2
2	D/K		
3	Stopped		
(c) Did you stop using the (most recent method) in order to become pregnant?			
1	Yes	1	2
2	No		
THOSE WHO USED 1 OR 2 METHODS ONLY			
43. (a) In what month and year did you start to use (FIRST METHOD) after your (first, second, etc) pregnancy ended - that is, the one that ended in....?			
Month			
Year			
(b) In what month and year did you stop using (FIRST METHOD)?			
Month			
Year			
(c) In what month and year did you start using (SECOND METHOD)?			
Month			
Year			
(d) In what month and year did you stop using (SECOND METHOD)?			
Month			
Year			

PREGNANT NOW, Q.10, 1
MARITAL STATUS,
Q. 34 and 39
SECOND/UNCERTAIN
Q.18, 1 and 2
STERILE Q.18, 3

PRIORITY
CODING

44.	INTERVIEWER CODE	1 Currently pregnant	1 GO TO Q.35, PAGE 19
		2 Not pregnant or D/K	2 CODE 3 OR 4 BELOW
		3 Married and living with spouse	3 CODE 5 OR 6 BELOW
		4 Separated, divorced, widowed	4 GO TO Q.48 OVER PAGE
		5 SECOND/UNCERTAIN	5 ASK Q.45
		6 Sterile	6 GO TO Q.48 OVER PAGE
45.	(USE CARD A) Since the end of your last pregnancy (that is, since NAME OF CHILD was born) have you or your husband used any method to avoid your becoming pregnant? (a) What method or methods have you used, starting with the first you used:	Yes No	1 ASK (a) GO TO Q.47
	1st		
	2nd		
	3rd		
	4th		
46.	Are you or your husband currently using a method? (a) What method are you using?	Yes No	1 ASK (a) GO TO Q.47
47.	Are you not using a method at present in order to become pregnant, or for some other reason? To become pregnant Other reason	1 2	GO TO Q.49 OVER PAGE

THOSE SEPARATED/DIVORCED/WIDOWED OR STERILE

(USE CARD A)

48. After your last pregnancy ended (that is, after NAME OF CHILD was born) did you or your husband use any method to prevent your becoming pregnant at any time?

(a) What method or methods did you use, starting with the one you used first:

1st
2nd
3rd
4th

THOSE WHO USED 1 OR MORE METHODS ONLY

DNA: Used no method X
DNA: Used 3 or more methods Y

49. (a) In what month and year did you start to use (FIRST METHOD) after your last pregnancy ended in....?

Month
Year

(b) In what month and year did you stop using (FIRST METHOD)?

Month
Year

Still using

DNA: Used 1 method only X

(c) In what month and year did you start to use (SECOND METHOD)?

Month
Year

(d) In what month and year did you stop using (SECOND METHOD)?

Month
Year

Still using

GO TO Q.55,
PAGE 19

MARITAL STATUS,
Q.38 AND 39
STERILE, Q.18, 3

1
2
ASK (a)
GO TO Q.55,
PAGE 19

EVER PREGNANT
Q.12, BOX H
SECOND
Q.16, CODE 1
UNCERTAIN
Q.18, CODE 2
STERILE
Q.19, CODE 3
CONABIT, Co. 38, 39

THOSE WHO HAVE NEVER BEEN PREGNANT DURING CURRENT/MOST RECENT MARRIAGE

50. INTERVIEWER CODE

Living with husband and fecund/uncertain X
Living with husband and sterile Y
Not living with husband Z

51. (HAND CARD A TO INFORMANT)

Have you and your (present) husband ever used any of these methods to prevent your becoming pregnant?

(a) What method or methods have you used, starting with the first you used:

1st
2nd
3rd
4th
RECORD IN ORDER USED

(b) What method, if any, are you and your husband currently using?

52. Are you not using a method at present in order to become pregnant, or for some other reason?

To become pregnant
Other reason

53. (HAND CARD A TO INFORMANT)

Did you and your (last) husband ever use a method to prevent your becoming pregnant?

Yes
No

ASK (a)
GO TO Q.55
PAGE 19

(a) What method or methods did you use, starting with the first you used:

1st
2nd
3rd
4th
RECORD IN ORDER USED

GO TO Q.55
PAGE 19

DNA: Has used no method X
DNA: Used 3 or more methods Y

THOSE WHO USED 1 OR 2 METHODS ONLY

54. (a) In what month and year did you start to use (FIRST METHOD)?

Month
Year

(b) In what month and year did you stop using (FIRST METHOD)?

Month
Year

GO TO Q.54
OVER PAGE

ASK Q.52

DNA: Used 1 method only X

(c) In what month and year did you start to use (SECOND METHOD)?

Month
Year

(d) In what month and year did you stop using (SECOND METHOD)?

Month
Year

Still using

GO TO Q.55
PAGE 19

TO ALL

55. Are you registered with a doctor under the National Health Service?

(a) or have you another doctor?

(b) Is there more than one doctor working in the practice, or only one?

(c) Is the doctor (you usually see) a man or a woman?

(d) How long is it since you last went to see your own doctor (either for yourself or for your children)?

Less than 1 year ago
1 year ago or more
2 years or more
Can't remember

56. (a) About how long did it take you to get from home to your doctor the last time you went (for yourself or your children)?

Less than ¼ hour
¼ hour but less than ½ hour
½ hour but less than 1 hour
1 hour but less than 2 hours
2 hours or more
Can't remember

(b) And did you go:

by bus
by car
on foot only
or how (specify)

ASK (b)-(d)

ASK (a)

ASK (b)-(d)

GO TO Q.57.

PAGE 21

56 (cont'd)

(c) Did you make an appointment to see him or not?

Yes
No

(d) How long did you have to wait there before you saw the doctor the last time you went (after the time of your appointment)?

Less than ¼ hour
¼ hour but less than ½ hour
½ hour but less than 1 hour
1 hour but less than 2 hours
2 hours or more
Can't remember

(e) So how long did the visit take from home to doctor, including the time you spent there?

Less than ¼ hour
¼ hour but less than ½ hour
½ hour but less than 1 hour
1 hour but less than 2 hours
2 hours or more
Can't rememberEXCLUDE TIME SPENT
SHOPPING ETC ON WAY
TO & FROM DOCTOR'S

(f) On how many mornings (... lunchtimes, ... afternoons, D/K (... evenings) a week does he have a general surgery (or does he have a private clinic) and how many of them? (If you can't see

GO TO (h)

PROMPT EACH DAY - AND PUT TICK IN APPROPRIATE BOXES

(before 12.0 noon) Morning
(12.0 - 2.0) Lunchtime
(after 2.0-6.0 pm) Afternoon
(after 6.0 pm) Evening

MON. TUE. WED. THU. FRI. SAT. SUNDAY

No. of days known

Mornings

Lunchtimes

Afternoons

Evenings

Total number of days known to be available

THOSE WITH NATURAL/STEP/FOSTER CHILDREN UNDER 5 YEARS IN HOUSEHOLD

DATA: No children under 5 years in household

(g) When you have to go to the doctor (or yourself) do you usually have to take (CHILDREN) with you or not?

Yes
No

TO ALL WHO HAVE A DOCTOR

(h) Thinking of the time it takes and the times of surgery hours, is it difficult for you to arrange to go there or not?

Yes, difficult
No

SEE HOUSEHOLD COMP. SHEET

GO TO (h)

19

20

59 (cont'd)

(1) To it not yet time for another visit, or what?

Not yet time for another visit
Has returned for supplies/prescription
since last seeing doctor
Other (specify)

60. THOSE WHO HAVE NOT RECEIVED ADVICE ETC FROM ANY SOURCE

TPNA: Has received advice from a source X

(1) IF ALREADY KNOWN. CODE (a) AND ASK (b))

(a) Have you ever thought of asking your own doctor for

Yes, has asked already	Yes, other	No Other (specify)
-------------------------------	-------------------	-------------------------------

(1) Are you: still making up your mind about it

definitely planning to go

or did you decide against it?

Other (specify)

(ii) Have you actually made an appointment to see him about this?

1444) When is the appointment for?

(1v) When did you make this appointment?

OFF. USE

60 (cont'd)

(IF ALREADY KNOWN. CODE (b) AND GO TO Q.59)

(b) Have you ever thought of going to a family planning clinic for advice on contraception
Yes, has asked air or not?

Yes
No
Other (specify)

(i) Are you:
RUNNING PROMPT

still making up your mind about it
definitely planning to go
or did you decide against it?
Other (specify)

(11) Have you actually made an appointment to go there?

(111) When is your appointment for?

(iv) When did you make this appointment

DO NOT HAVE NOT RECEIVED ADVICE ETC FROM ANY SOURCE

(c) If you do decide in the future that you'd like advice on contraception, do you think you'd go to your doctor or to a family planning clinic?

$$\text{ASK} \quad (111) - (1\bar{1}\bar{1})$$

GO TO (b)
OVER PAGE

Day Mth Year

OFF. USE

(d) If you were to obtain contraceptive advice for yourself, would you prefer to get that advice from:

ADMINISTRATIVE APPROVAL

Wouldn't mind if woman or man as long as from doctor
D/K, haven't thought
Other specify)

Wouldn't mind if woman or man as long as from doctor
D/K, haven't thought
Other (specify)

THOSE WHO HAVE BEEN TO FAMILY DOCTOR FOR CONTRACEPTIVE ADVICE

FAMILY DR.
0.57, CODE 1

GO TO Q.72

72 (cont'd)

IF KNOWS DAYS/TIMES AVAILABLE

1

71. (a) In fact, do/did you ever have to undress or change when you went to your doctor for contraceptive advice, to make your pants, stockings, ties, or anything else?

Yes
No
Don't remember

(b) Where do people change or undress there?

Running Prompt { In a cubicle alone
Behind a screen
Or where? (specify) }

D/K, can't remember

IF HAS EVER UNDERESSED

(c) (1) Are/were you given a dressing-gown to wear after you have/had undressed?

Yes
No
Don't remember

(11) After you have/had undressed, where do/did you wait to see the doctor.
In the: Running Prompt { a room or cubicle alone
or where? (specify) }

(d) Have you ever had a fitting or an internal examination for a contraceptive method by your doctor?

Yes
No
Don't remember

72. Does your doctor (or one of his partners that you can consult) have any special sessions or time just for giving contraceptive advice and prescriptions?

Yes
No
D/K

(a) On how many mornings (...lunchtimes, ...afternoons...) are/were the family planning sessions held here? ----- D/K

PROMPT EACH DAY - AND PUT TICK IN APPROPRIATE BOXES

	MON.	TUE.	WED.	THUR.	FRI.	SAT.
(before 12.0 noon)						
(12.0 - 2.0)						
(after 2.0-6.0 pm)						
(after 6.0 pm)						

Number of days known to be available per week

31

2

(b) So is it (would it be) fairly easy for you to arrange to go at these hours or not? Yes, fairly easy
Not easy
Other (specify)

3

ASK ALL

(c) When would be the most convenient time of day for you to go to your doctor for family planning advice (if you wanted to go):

Running Prompt { mornings
lunchtimes
afternoons
or evenings?
D/K, haven't thought
Other (specify) }

1

2

3

4

5

6

73. Is there anything else you would like to say about going to your own doctor for advice on contraception?

Nothing else X
Other Y

Yes

No

D.K

1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

1

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1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

1

2

3

32

FINAL QUESTION

Is there anything else you would like to say about family planning, the services, or this interview?

head of unemployed, note and record
last occupation; if divorced/separated
record husband's occupation at time of
separation)

separation)

Self-employed ;

JOB TITLE

JOB DESCRIPTION	DATE	TIME	LOCATION	STATUS
...

JOB DESCRIPTION

MINISTRY

6. EMPLOYMENT STATISTICS

In full-time

Not in

1000-0000/01/0000-0000\$05.00/0

any. do you/da

belong to?

Church of England
rectorials/

Church of Scotland

Jewf

Other (specify)

.....

.....

.....

.....

100

114

34

FAMILY PLANNING SERVICES II

SINGLE WOMEN

Serial No.

Address No.				
H'hold No.				
Pers. No.				

Interviewer's Name

Auth. No.

☐

Day

Mth

Yr

Date of Interview

75

(A) At what type of address does the informant live?	1 GO TO (B) 2 GO TO Q.1	1 GO TO (B) 2 GO TO Q.1
(B) Is the informant's name on the address list?	1 Yes 2 No	1 Yes 2 No
1. First of all can you tell me what do the words "family planning" mean to you? (IF NECESSARY, PROMPT: When you see the words "family planning" what do you think of?)		
2. What do you think is about the right number of children in a family? (ACCEPT RANGE IF SPONTANEOUSLY GIVEN) D/K, haven't thought X Other (specify) Y		
3. Are you engaged or have you a boyfriend at present?	1 Engaged 2 Boyfriend 3 Neither	
4. Do you think you will marry at some time?	1 Yes 2 No 3 D/K	

4 (cont'd)

(a) Do you think you may have children in the future, even if you don't marry?

Yes
No
D/K

1 ASK (b) & (c)
2 GO TO Q.7
3 ASK (D) & (c)

(b) How many children do you think you'd like to have (when you marry)?

(ACCEPT RANGE IF SPONTANEOUSLY GIVEN)

99

D/K, haven't thought

(c) Assuming you are physically able to have children, indicate the number of children you might expect to have. If children you finally decide to have?

5. (a) Do you think you would prefer to have a baby as soon as possible after you marry or to wait a little while first?

1 Have baby as soon as possible
2 Wait a little while first
3 D/K, haven't thought
Other (specify)

1 GO TO Q.6
2 ASK (b)
3 GO TO Q.6

(b) About how soon after you married would you like your first child to be born?

MINIMUM NUMBER OF MONTHS AFTER MARRIAGE

D/K, haven't thought

99

ASK IF WANTS MORE THAN 1 CHILD. OTHERS GO TO Q.7

6. (a) Would you like to have (all/both) your children close together, or to space them out?

1 Close together
2 Space them out
3 D/K, haven't thought
4 Other (specify)

(b) What do you think is the best gap to have between children's ages?

MINIMUM NO. OF MONTHS

D/K, haven't thought

99

7. What places or people do you know of that give(s) advice on contraception - ways or preventing pregnancy - that you could get to easily, if you wished?

Knows one or more places/people
Knows none X

(a) Do you know of anywhere at all that gives advice on contraception?

Yes
No

(b) What places or people do you know of?

LIST AT A BELOW AND ASK (c) - (d)

(c) Do any of the places/people you mentioned provide advice on contraception to single people?

(i) Which ones?

RING CODE 1 UNDER B BELOW FOR EACH MENTIONED, THEN ASK (d)

(d) Do you know of anyone or anywhere (else) that provides advice on contraception to single people?

Yes
No

(i) Which places or people?

LIST AT A AND RING 1 UNDER B

A PLACES KNOWN	B SINGLE PEOPLE	
	OFF USE	USE
	1	
	1	
	1	
	1	

8. What methods of contraception - ways of preventing pregnancy - have you heard of?

(IF NECESSARY, SAY: If you don't know the actual name just tell me in your own words)

ASK (a)
LIST AT A
BELOW AND
ASK (c)&(d)

(i) Have you heard of the pill?

ASK (b)-(d)
GO TO (d)

(ii) Are there any other methods of preventing pregnancy that you have heard of?

ASK (i)
GO TO (d)

Knows none X

Yes X

No Y

Yes (specify) X

No others known Y

9. (When/if you (did) marry, do you think you (will/would) take precautions to limit the number of children you (have/had) or not?

ASK (i)
GO TO Q.8

Yes
No
D/K, haven't thought
Other (specify)

(a) Would you want to use a method of contraception/birth control:

as soon as you got married
or wait until you had as
many children as you wanted
or what? (specify)

(b) Why do you think you won't take precautions?

ASK (i)

CODE 4, ON
REMINDER
CARD AND
ASK (ii)
GO TO Q.9

CODE ON
REMINDER
CARD

1 ASK (a)
2 GO TO (b)
3 }
4 GO TO Q.10

Q.9, CODE 2		11. While we have been talking, have you thought of any other ways of preventing pregnancy - including the kind of precautions taken by men/boys?	No X Yes Y	GO TO Q.12 CODE NEW METHODS MENTIONED REMINDER CARD
1 GO TO (b) 2 ASK (1) 3 4 GO TO (b) 5 6				
TO ALL WHO NAMED METHODS AND HAVE NOT REJECTED INTERCOURSE BEFORE MARRIAGE DNA: Wouldn't have intercourse before marriage		Q.10 (b) CODE 5		
12. Which, if any, of the methods you've mentioned have you had experience of - including the kind of precautions taken by men/boys? CODE ON REMINDER CARD		1 GO TO Q.14		

13. If you found yourself in a situation where you yourself had not taken precautions, would you:		1 make sure your boyfriend took precautions 2 find it too embarrassing to make sure 3 think it too unromantic to mention 4 or would you probably not think about it at the time? 5 Other (specify)
HAND A CARD AND PROMPT RUNNING PROMPT		
GO TO Q.11 ASK (1) GO TO Q.11		

10. (a) You mentioned you'd heard of....(PROMPT METHODS FROM REMINDER CARD). (If/when) you (are) married, do you think you or your husband (would be/are) likely to use:

RUNNING - []
 (the method you mentioned/
 one of the methods you mentioned/
 or some other method?)
 PROMPT
 CODE ANSWERS ON REMINDER CARD
 Don't expect/intend to marry D/K, no idea
 Other (specify)

(1) Which method are you most likely to use?

CODE ON REMINDER CARD

(b) You mentioned you'd heard of....(PROMPT METHODS FROM REMINDER CARD). Whilst you are single, do you think you and (your/s) boyfriend are likely to use:

RUNNING - []
 (the method you mentioned/
 one of the methods you mentioned/
 or some other method?)
 PROMPT
 CODE ANSWERS ON REMINDER CARD
 D/K, no idea
 Wouldn't have intercourse before marriage
 Wouldn't use a method
 Other (specify)

(1) Can I just check, which method are you and (your/s) boyfriend most likely to use?

CODE ON REMINDER CARD

14. INTRODUCE AS NECESSARY ALONG THE LINES OF: Advice on contraception - ways of preventing pregnancy - is available for unmarried people, but at the moment we don't know how many single people have been able or wanted to take advantage of this, so could I just ask:

(a) Have you, as an individual, ever been advised to use or prescribed a contraceptive method by:

FAMILY DOCTOR Your family doctor (or one of his partners) ...
CLINIC A doctor in a hospital family planning clinic...
A doctor in any other family planning clinic...
A doctor in any other clinic (specify) ...
Any other doctor (specify).....
CLINIC A nurse at a family planning clinic without EVER seeing the doctor there?
FAMILY DOCTOR A nurse at your own doctor's without ever seeing your doctor about contraception.....
CLINIC Have you obtained supplies from a family planning clinic without ever seeing a doctor or a nurse at that clinic about contraception
None of these [] and couldn't have intercourse before marriage
Other

9 GO TO Q.17(c)(f)
10 GO TO Q.17,
PAGE 9

IF MORE THAN ONE SOURCE HAS GIVEN ADVICE ETC - ASK (b).
OTHERS' TRANSFER CODE FROM COL. (a) TO COL. (b) AND GO TO Q.15

(b) Of the people you mentioned who last advised you to use or prescribed or supplied a method?
RECORD ABOVE IN COL. (b). THEN ASK Q.15.

15. (a) The last time you went to about contraception what method was advised, prescribed, fitted or supplied?

METHOD advised/prescribed/fitted/supplied (specify)

None/general discussion only
None, pill for periods only

1 SPECIFY,
THEN GO TO (b)
OVER PAGE
2 ASK (f) AND
3 (f) OVER PAGE

IN COL. (a), Q.14

15. (a) (cont'd)

IF MORE

(f) What sort of advice was given to you?

(ii) How long ago was that?

Less than 3 months
3 months but less than 6 months
6 months but less than 1 year
1 year but less than 2 years
2 years but less than 5 years
5 years ago or more
Can't remember

1
2
3
4
5
6
7

TREAT AS
NOT HAVING
HAD ADVICE
AND GO TO
Q.17, PAGE 9

IF METHOD ADVISED, ETC

(b) (Could I just check) did you use this (any of these) method(s) following your last visit or not?

Yes
No

GO TO Q.16
ASK (f)

(i) Do you intend to use this (one of these) method(s) within:

the next month
the next three months
later than that
or not at all
other (specify)

RUNNING PROMPT

1
2
3
4
5

16. When did you last see..... about contraception?

- Less than 6 weeks ago
6 weeks but less than 2 months
2 months but less than 3 months
3 months but less than 6 months
6 months but less than 1 year
1 year but less than 2 years
2 years but less than 5 years
5 years ago or more

(a) Why have you not been back since then?

- No need to go, etc
Has recently moved
Other (specify)

(i) Is it not time yet for another visit, or what?

- Not yet time for another visit
Has returned for supplies/prescription since last seeing doctor
Other (specify)

Q-14, CODE 10
Q-15(a), CODE 2 OR 3

17. IF ALREADY KNOWN, CODE (a) AND ASK (b)

- (a) Have you ever thought of asking your own doctor for advice on contraception whilst you are single, or not? Yes, has asked already
Yes, other
No
Other (specify)

17. (a) (cont'd)

(i) Are you:

RUNNING
PROMPT

- still making up your mind about it did you decide against it or are you definitely planning to go or what? (specify)

- 1 GO TO (b)
2 ASK (ii)
3 GO TO (b)
4

(ii) Have you actually made an appointment to go and see your doctor about this?

- Yes
No

(b) Have you ever thought of going to a family planning clinic for advice on contraception?

- Yes
No
Other (specify)

- 1 ASK (i)
2 GO TO (c)
3

(i) Are you:

RUNNING
PROMPT

- still making up your mind about it did you decide against it or are you definitely planning to go or what? (specify)

- 1 GO TO (c)
2 ASK (ii)
3 GO TO (c)
4

(ii) Have you actually made an appointment to go to a clinic?

- Yes
No

(c) If you do later decide that you'd like advice on contraception whilst you are single, are you most likely to go to:

RUNNING
PROMPT

- your own doctor
or a family planning clinic?
D/K, haven't thought
Wouldn't want advice at all
Other (specify)

- 1 GO TO (b)
2 ASK (i)&(ii)
3 GO TO (b)
4

- 1 ASK (d)
2
3
4 GO TO (e)
5

17. (cont'd)

(d) And would you prefer to go to:

RUNNING PROMPT — [] your own doctor
[] an ordinary family planning clinic
[] or a clinic specializing in contraceptive advice
[] D/K, haven't thought

120

TO ALL

(e) Would you prefer to get contraceptive advice for yourself from:

RUNNING PROMPT — [] a woman doctor
[] a man doctor
[] or wouldn't you mind?
[] D/K, haven't thought
[] Other (specify)

(f) And when (if) you marry, do you think you (will/would be) most likely to go for contraceptive advice from:
[] a family planning clinic
[] or to no one?
[] D/K, haven't thought
[] Other (specify)

11

TO ALL UNLESS REJECT INTERCOURSE BEFORE MARRIAGE

DNA: Wouldn't have intercourse before marriage Y

Q.10(b), CODE 5
GO TO Q.22,
PAGE 14

ASK FOR CLINIC AND REPEAT FOR FAMILY DOCTOR BEFORE ASKING (a) IF NECESSARY

18. I'm going to read out some comments other people have made about going to a clinic (their doctor) for advice on contraception when they are single, and I'd like you to say how far you agree or disagree with each comment:

HAND CARD B
AND PROMPT

I (have found/would find) going to (a clinic/your own doctor) for contraceptive advice:

1. Embarrassing...
2. The way to get expert advice..
3. Difficult to arrange.....
4. Expensive to travel there
5. The way to get sympathetic advice.....
6. Private enough.....
7. Too much bother
8. Unnecessary.....

CLINIC					FAMILY DOCTOR						
Compe- tely to agree	In- clined to dis- agree	Compe- tely to dis- agree	Neither agree nor dis- agree	D/K, haven't thought	Compe- tely to dis- agree	In- clined to dis- agree	Compe- tely to dis- agree	Neither agree nor dis- agree	D/K, haven't thought		
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3*	4*	5	6	1	2	3*	4*	5	6
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3	4	5	6	1	2	3	4	5	6
1	2	3	4	5	6	1	2	3	4	5	6

*IF DISAGREES THAT IT IS WAY TO GET SYMPATHETIC ADVICE

(a) In what way (have you found they were not/do you think they would not be) sympathetic?

CLINIC

DOCTOR

12

THOSE WHO HAVE BEEN TO OWN DOCTOR FOR ADVICE. OTHERS GO TO Q.27

Q.14, CODE 1

26. When you first went to your own doctor about contraception, did he/she know you were unmarried?

Yes
No

1 GO TO (b)
2 ASK (a)

(a) Did you say you were unmarried, or did you feel you had to say you were married?

Said unmarried
Said married
Other (specify)

1
2
3

(b) Did your doctor raise the subject of contraception in the first place, or did you raise it yourself?

Doctor raised subject
Informant raised subject
Other (specify)

1
2
3

TO THOSE WITH A DOCTOR

27. Is there anything (else) you'd like to say about going to your own doctor for advice on contraception whilst you are single?

Q.23(a) OR (a) (1),
CODE 1

TO ALL

28. (a) Do people nowadays normally have to pay their own doctors for:

contraceptive advice?
making out the prescription for contraception?
contraceptive supplies?

Yes No D/K
1 1 1
2 2 2
3 3 3

(b) Do people nowadays normally have to pay at clinics for:

contraceptive advice?
the prescription for contraception?
contraceptive supplies?

1 1 1
2 2 2
3 3 3

CLASSIFICATION

1. INFORMANT'S DATE OF BIRTH	5. FATHER'S OCCUPATION	6. PARENTS' COUNTRY OF BIRTH	Mother	Father
Day Month Year	If retired, dead or unemployed, record last occupation and note				1 2 3 4 5 6	1 2 3 4 5 6
2. INFORMANT'S PLACE OF RESIDENCE	JOB TITLE	6. PARENTS' COUNTRY OF BIRTH	Mother	Father
1 Lives with parents 2 Lives with other relative 3 Lives in flat or digs 4 Lives in lodgings or hall of residence and is catered for 5 Other (specify)	Self-employed Employee				1 2 3 4 5 6	1 2 3 4 5 6
3. EMPLOYMENT STATUS	INDUSTRY	6. PARENTS' COUNTRY OF BIRTH	Mother	Father
1 Working full-time 2 Working part-time 3 In full-time education at school 4 In full-time education at college/university 5 Unemployed 6 Other					1 2 3 4 5 6	1 2 3 4 5 6
4. AGE OF COMPLETING (INTENDING TO COMPLETE) CONTINUOUS FULL-TIME EDUCATION		6. PARENTS' COUNTRY OF BIRTH	Mother	Father
1 15 or under 2 16 3 17 4 18 and over					1 2 3 4	1 2 3 4

7. Is there anything else you would like to say about the family planning services, or this interview?

DURATION OF INTERVIEW - MINUTES

Appendix 2

Sampling report

1. The sample populations

The survey covered two populations:

- (i) single women aged approximately 16-40 at the time of interview (ie born 12.3.34-11.3.59 inclusive).
- (ii) married women aged approximately 16-54 at the time of interview (ie born 12.3.20-11.3.59 inclusive).
Separated, divorced, widowed and co-habiting women were included as married for the purposes of sampling.

2. The sampling frame

No national list of these two groups of women exists. The Electoral Register does not specify marital status or age and we therefore drew a sample of addresses from the Electoral Register from which to identify those women eligible for the survey.

The survey was restricted to those women living in private households because the Electoral Register has an incomplete coverage of institutions and no list of institutions was available to us at the time we were conducting this survey.

3. Sample sizes

Since the data from this survey were to be com-

pared with the results from the previous Family Planning Survey, we felt it was important to have at least as many women in the same age groups as were covered in 1970. On the 1970 Family Planning Survey we drew a sample of 11,000 addresses in order to identify approximately 2,600 married women aged 16-40 and 1,000 single women aged 16-35. However in 1975 DHSS were interested in the experiences of older women and, therefore, wanted the age ranges to be extended. We decided to select a sample of 11,000 addresses to identify married women aged 16-54 and single women aged 16-40.

Table 1 Distribution of female population enumerated in private households (England and Wales) from 1971 Census*

Marital status	16-40 years	16-54 years
Single	2,156,219	—
Married, widowed, divorced	—	9,291,320

*In this and the following tables numbers are not distinguished from percentages by being printed in italics. This differs from the main body of the report.

From the 1971 Census the number of private households in England and Wales was 16,434,075. Previous samples showed that the estimated average number of households per address was 1.02 and we therefore estimated that there were 16,111,838 addresses. Thus we expect a sample of 11,000 addresses to contain:

Table 2 Sample distribution

Area category	1973 Population estimate	Percentage of population in category	Allocation of districts		No of wards per district	No of addresses per ward	No of addresses in category	Percentage of addresses in category
			Theoretical	Actual				
Non-metropolitan districts								
Northern	1,933,970	3.9	3.89	4	4	25	432	3.9
Yorks & Humberside	1,492,060	3.0	3.00	3	4	28	336	3.1
North Western	2,258,570	4.6	4.54	4	4	32	512	4.7
East Midlands	3,695,970	7.5	7.44	7	4	30	840	7.6
West Midlands	2,377,800	4.8	4.78	5	4	27	540	4.9
East Anglia	1,738,960	3.5	3.50	3	4	32	384	3.5
South East	9,737,300	19.8	19.60	20	4	27	2,160	19.7
South West	4,174,380	8.5	8.40	8	4	29	928	8.4
Wales	2,749,280	5.5	5.53	6	4	25.5	612	5.5
Metropolitan districts								
Northern	1,198,390	2.4	2.41	2	4	34	272	2.5
Yorks & Humberside	3,398,710	6.9	6.84	7	4	27	756	6.9
North West	4,350,680	8.8	8.75	9	4	27	972	8.8
West Midlands	2,785,460	5.7	5.60	6	4	26	624	5.7
GLC	7,281,080	14.8	14.65	15	4	27	1,620	14.7
Total	49,172,610	100	99	99	—	—	10,988	100

	$2,156,219 \times 11,000 = 1,470$	single women
	16,111,838	aged 16-40
and	$9,291,320 \times 11,000 = 6,340$	married
	16,111,838	women aged 16-54

If we assumed an overall response rate of about 70 per cent then we would expect to achieve interviews with 4,440 married women and 1,030 single women. The sample was subsequently reduced in size because insufficient resources were available for the survey (see paragraph 6.3).

4. Sampling procedure

A national four stage stratified design was used: the stages being districts, wards, addresses and, finally, eligible women.

4.1 Selection of addresses *Stage 1—sample of districts*

All local authority new districts in England and Wales were allocated to ten strata according to the Registrar General's standard regions. Within standard regions the districts were stratified into metropolitan and non-metropolitan districts. Since some standard regions did not contain any metropolitan counties, fourteen categories were formed in this way (see Table 2).

We wished to select 99 districts in total, this being a compromise between the necessity to cluster the sample to make economic use of interviewing resources and the desirability of scattering the sample widely in order to obtain more accurate results.

We allocated the 99 districts over the fourteen categories in proportion to their population size. This distribution—the 'theoretical distribution'—is shown in Table 2. Within each category the districts were ranked in descending order of population size and the appropriate number of districts was selected. The chance of any district being selected was in proportion to its population. If district A had twice as large a population as district B, it was given twice the chance of being selected. Table 2 shows the distribution of the districts (the primary sampling units) by standard region and area type. The theoretical and actual distributions differ because of rounding.

Stage 2—sample of wards

Wards were selected as intermediate sampling units. Wards containing fewer than 2,200 electors were grouped with contiguous wards. In each selected district we drew a random sample of four wards, or groups of wards, with the chance of selection of a ward being in proportion to its electorate.

Stage 3—sample of addresses

A systematic random sample of approximately 11,000 addresses was drawn from the Electoral Register for the 396 selected wards (or groups of wards). It has already been pointed out that the actual distribution of districts differed from the theoretical distribution because of rounding, and so we compensated for this by selecting differing numbers of addresses per district. The number of addresses per ward within each district was constant.

4.2 Probability of selection of an address This sampling method gives each address listed on the Electoral Register an equal chance of selection providing two assumptions are made:

- (a) the ratio of addresses to electorate per ward is constant
- (b) the ratio of population to electorate per district is constant.

5. Identification of eligible women

We identified eligible women by means of a postal sift, since this was cheaper than an interviewer sift. The occupier of each selected address was sent, by post, a simple questionnaire accompanied by an explanatory letter. This questionnaire asked for the name, date-of-birth, sex and marital status of everyone living at the address. We asked for the dates of birth of everyone rather than specifying an age range because previous research has shown that some people at the limits of the specified age range tend to put themselves outside the range, causing deficiencies in the numbers in certain age groups and thereby introducing bias.

Two reminder letters were sent at fortnightly intervals to those addresses from which we had not received replies.

6. Selection of eligible women

6.1 Selection procedure Two sampling procedures were considered

- (1) Including only the women who were identified as eligible from the postal questionnaire.
- (2) Identifying all the addresses which contained at least one eligible woman and then including all the eligible women living at these addresses when the interviewer calls.

The second method means that the sample is deficient in eligible women who have moved (between the postal and interview stages) to addresses at which no-one was eligible at the postal stage. However we calculated that this group would contain less than 2 per cent of the eligible population, since 8-12 per cent of the population move annually and so we estimated

that 2-3 per cent moved between the postal and interview stages and we assumed that about half of these would have moved to 'ineligible addresses'.

We decided, nevertheless, to adopt this method since it did not involve tracing movers, and was therefore cheaper, and since it picks up unlisted eligible women. This was considered an advantage, particularly in multi-household addresses where there is a danger that information given on the postal form relates to households rather than the whole address.

The second method had the advantage that identical sampling methods could be employed for the two sample types (ie responding and non-responding to the postal stages).

In retrospect it might have been preferable to use a combination of the two sampling methods: this would have involved tracing movers and including those women who were living at the selected addresses and had been there at the time of the postal sift but who were not listed on the postal forms.

6.2 Responding and non-responding samples In addition to allocating to interviewers those addresses which contained at least one eligible woman according to the postal form, we also allocated a random sample of half of the addresses which failed to return a postal form. Recall on these addresses was undertaken in case the eligible women living at them differed from those who responded to the postal enquiry. This was considered necessary because of the likelihood that people who do not return questionnaires differ from those who do. In particular, the previous family planning survey had shown that the addresses which did not reply to the postal stage contained proportionately more eligible women.

Properly since we recalled on one-half of the non-respondents to the postal they should have been weighted by a factor of 2 before adding them to the respondents, but this weighting was not carried out due to an oversight.

The error did not appear to affect the results, although the non-respondents differed somewhat from those who had responded to the postal enquiry. For example, although among married women a rather higher proportion of non-responders than of responders interviewed had used the services (29 per cent compared with 25 per cent)—apparently because they tended to be younger—re-weighting non-responders increased the proportion of all women who were current users only from 24.9 per cent to 25.1 per cent. A similar correction for those aged under 41 increased the percentage of current users from 36.9 per cent to 37.2 per cent.

6.3 Reduction in sample size Because of a reduction in the amount of money available for the survey, we systematically rejected 1 in 6 of both the responding and non-responding addresses. This meant that our expected sample sizes, described in paragraph 2, were reduced by $\frac{1}{6}$.

7. Response rates

7.1 Response at postal stage An overall response rate of 87 per cent was achieved to the postal survey. Table 3 lists the response rates by region.

Table 3 Response to the postal questionnaire

Standard region	Total no of addresses	Total no of responding addresses	Percentage of addresses which responded
Northern	704	641	91
Yorkshire and Humberside	1,092	980	90
North West	1,484	1,294	87
East Midlands	840	749	89
West Midlands	1,164	1,026	88
East Anglia	384	320	83
GLC	1,620	1,315	81
South East	2,160	1,900	88
South West	928	784	84
Wales	612	534	87
Total	10,988	9,543	87

Table 4 gives a breakdown of the addresses which responded to the postal questionnaire, showing the numbers of addresses which contained eligible women and the number of eligible women living at these addresses.

7.2 Sample allocated to interviewers A random sample of 4,516 (ie 5 out of 6) of the addresses which contained eligible women were allocated to interviewers. These addresses contained 1,055 single women and 4,278 married women according to the postal questionnaires. In addition a systematic random sample of 599 addresses, which failed to reply to the postal stage, were issued to interviewers.

7.3 Response at interview stage *Respondents to postal*

Interviewers contacted all 4,516 addresses of which 4,302 contained at least one eligible woman. Thirty-eight addresses were empty or demolished and at a further 48 addresses the eligible woman had moved or died and had not been replaced by an eligible woman. One hundred and twenty-eight addresses proved to be ineligible due to incorrect information on the postal form and this means that the expected sample sizes should be altered: We estimated that the 4,388 (ie 4,516-128) addresses, which were eligible at the postal stage, contained 1,023 single women and 4,150 married women at that time. By the interview stage we would have

Table 4 Distribution of eligible women at postal stage

Standard region	Total responding addresses	Addresses containing eligible women		Numbers of eligible women		
		Nos	%	Single	Married	Total
Northern	641	390	61	80	376	456
Yorks & Humb	980	520	53	132	498	630
North West	1,294	706	55	180	672	852
East Midland	749	417	56	80	405	485
West Midland	1,026	616	60	142	601	743
East Anglia	320	177	55	30	172	202
GLC	1,315	731	56	228	679	907
South East	1,900	1,160	61	264	1,120	1,384
South West	784	421	54	99	415	415
Wales	534	295	55	69	284	353
Total	9,543	5,433	57	1,304	5,222	6,526

expected 2-3 per cent of these women to have moved out and been replaced by only half that number. Thus we expected to identify approximately 1,009 single women and 4,097 married women in the appropriate age groups. In fact we found 870 single women and 4,201 married women. This is discussed in section 8.

Table 5 gives the achieved response rates of those women identified as eligible.

Table 5 Interview response rates at addresses responding to the postal

	Single	Married	Total
Women found eligible	870	4,201	5,071
Interviewed	800	3,673	4,373
Percentage response	80	87	86

Non-respondents to postal

The interviewers contacted 572 of the 599 allocated addresses which failed to respond to the postal questionnaire. Three hundred and forty-six of these addresses contained at least one eligible woman. The response rates are given in Table 6.

Table 6 Interview response rates at addresses which failed to respond to postal

	Single	Married	Total
Women found eligible	82	336	418
Interviewed	60	257	317
Percentage response	73	76	76

Final achieved sample

It was necessary to reject some of these interviews because of incomplete information, so that the final numbers of 'usable' interviews were 724 single and 3,898 married.

8. Sample validity

8.1 Sample deficit The figures given in paragraph 7.3.1 show that we identified fewer single women

than expected in the addresses which responded to the postal stage. Similarly if we compare the expected sample sizes, calculated from 1971 Census data, with the number of women identified as eligible at the interview stage for both sample types we see that there are deficiencies in both the married group and the single group.

Census data

From Census 1971 we expect 11,000 households to contain 1,470 single women aged 16-40 and 6,340 married women aged 16-54.

However as the sample was reduced by $\frac{1}{4}$ we revise these figures to 1,225 single and 5,283 married women.

Responding addresses

In the sample of addresses which responded to the postal survey, we identified 870 single and 4,201 married women eligible for inclusion.

Non-Responding addresses

In the sample of addresses which did not respond to the postal survey, we identified 82 single women and 336 married women. However we only contacted 572 out of 599 addresses allocated and allocated only half of the addresses which failed to reply to the postal stage. Thus we estimate that the addresses which did not respond to the postal stage contained 172 single and 704 married women in the relevant age groups.

Overall we estimate the number of eligible women identified on the survey to be 1,042 single women (a shortfall of 15 per cent when compared to Census data) and 4,905 married women (a shortfall of 7 per cent when compared to Census data).

It is difficult to explain why these deficiencies have occurred. In order to examine whether a bias in the sampling procedure carried out by interviewers could account for the shortfall, a recall

was carried out on a random sub-sample of 156 addresses. No indication of such a bias was found.

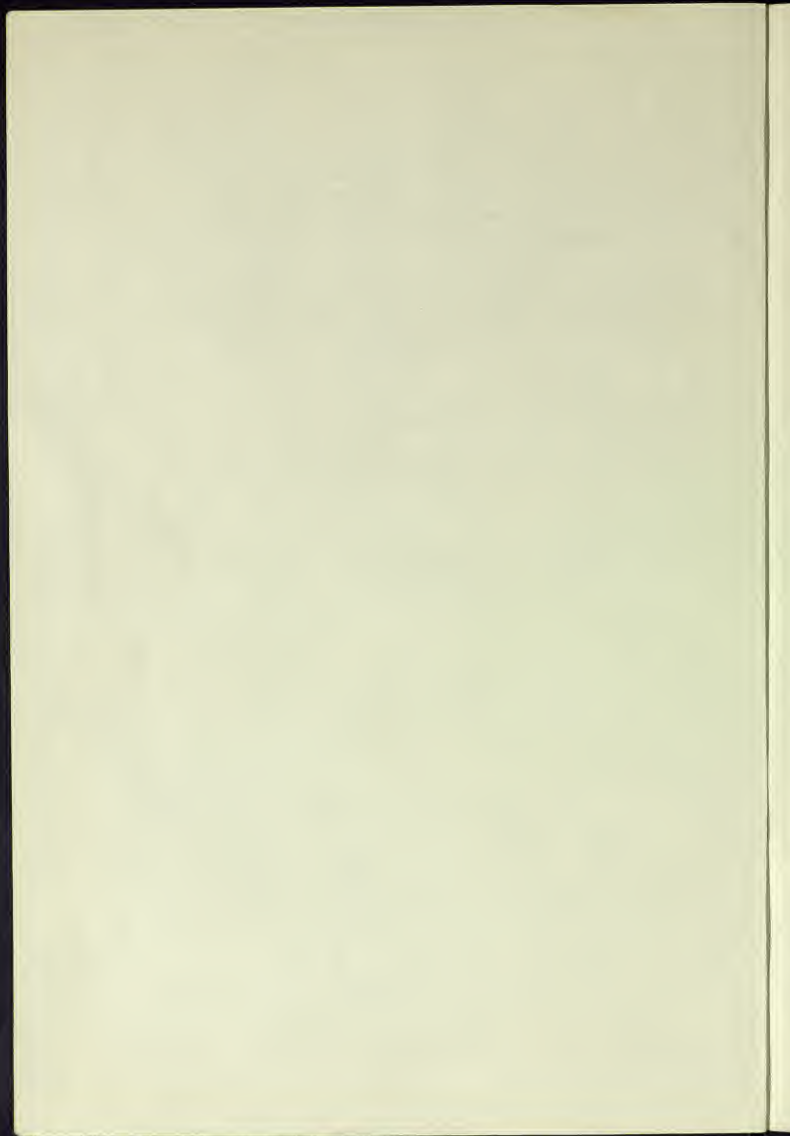
It seems likely that the shortfall is due to two factors, in addition to random sampling error:

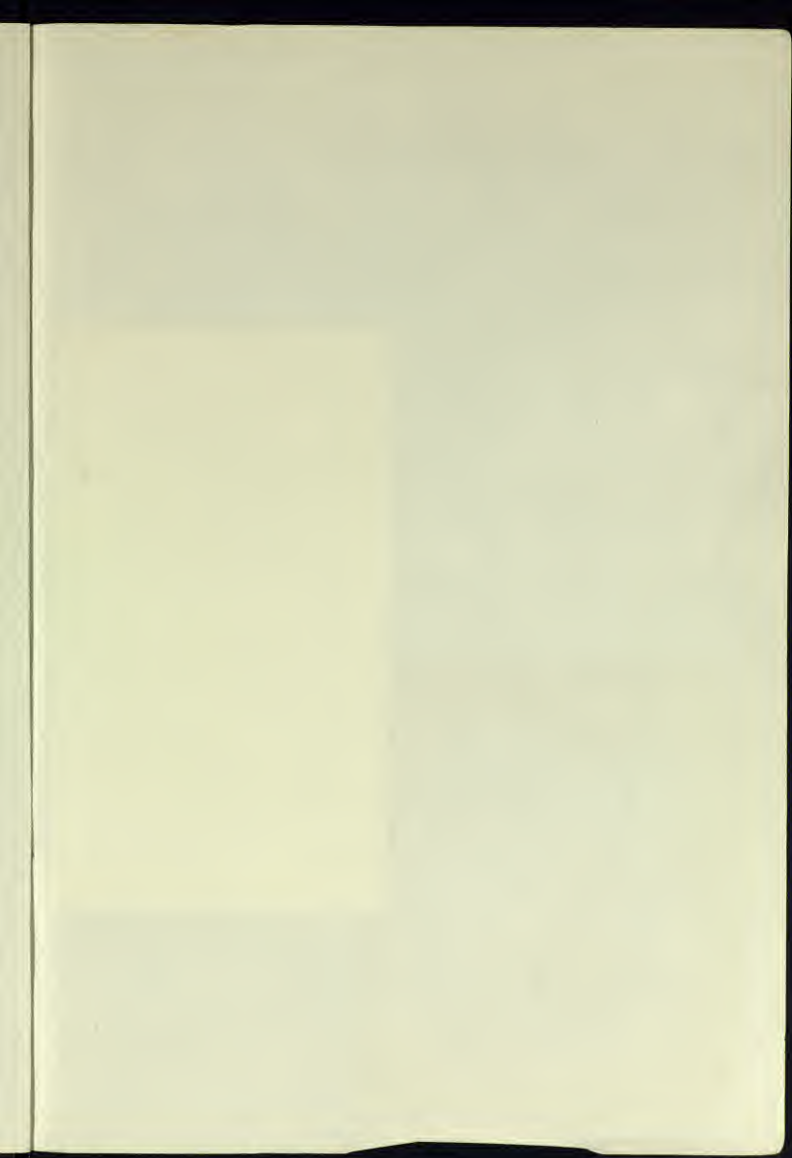
- (a) A higher proportion than 2-3 per cent of women moved in the relevant period. This is probable for the young single women who are particularly mobile.
- (b) Women moved out of the sampled addresses into 'ineligible' addresses, or into newly constructed buildings or institutions, neither of which are included in the sampling frame.

Some of the single women will have married between the postal and interview stages. Also there may be differences in the defini-

tion of married, co-habiting women entering themselves as 'single' on the postal form but being classified as 'married' in the interview. These two factors will affect the distribution between the single and married categories but do not explain a shortfall in both categories.

8.2 Comparison between respondents and non-respondents to the postal stage The sample of non-responding addresses contained a significantly higher proportion of eligible addresses than the responding addresses (66 per cent compared to 58 per cent). Similarly the addresses found eligible on the non-responding sample contained a higher proportion of single women than the eligible addresses in the responding sample. No differences were apparent for married women.





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